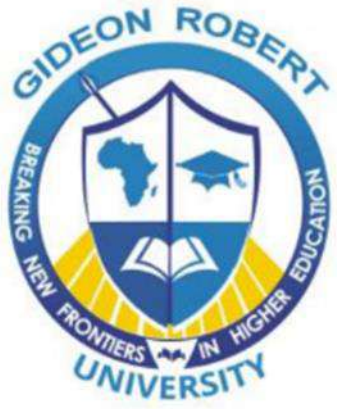


AN INTERGRATED APPROACH FOR SOCIAL WELFARE SECTOR AND HEALTH SECTOR

Thesis submitted in fulfilment of the requirements for the degree

Philosophy Doctor in social work (wellness healthcare and counselling)

By

Norman Mfanufikile Nkambule

At

Gideon Robert University

October 2022

Study leader: Prof. M. D. Herholdt (D.Phil.; Ph.D.)

Declaration of authenticity

I declare that the research project, *Title of the dissertation: subtitle*, is my own work and that each source of information used has been acknowledged by means of a complete reference. This dissertation has not been submitted before for any other research project, degree or examination at any university.

.....

(Signature of student)

. . . . . .

Abstract

With the fast growing and appreciation of the need for the contribution of wellness to achieve wellbeing in the holism of human functioning, attention to the subject of wellbeing needs to be explored and given much space for **wellness counselling**, **alternative medicine** and **holistic approach**. This dissertation will indicate how the wellness approach can be integrated to the **social welfare sector** and the **health care sector in South Africa**. A deeper understanding of the legislation of the country will be discussed in order assist all stakeholders to better integrate, and also establish gaps in the legislations that are relevant to this approach and recommend amendments if it is needed.

Currently, wellness is gaining increased interest in the health sector, regrettably there is a lack of drive from the side of government to properly regulate this sector. This thesis will explore wellness in order to encourage wellness counselors and holistic practitioners to contemplate their own wellbeing and to promote wellness for their clients. The dissertation will also strike a balance on practical and theoretical gaps. Some of the theoretical issues will be discussed here include the need for holistic wellness; theories wellness; assisting people of different background in our healthcare system, and ordinary people's perceptions of how a health practitioner should understand wellness issues.

This dissertation also offers key insights into the role that belief and consciousness play in facilitating holistic healthcare. It offers a unique integrated model drawn from these insights that repositions the client at the centre of diagnosis and treatment. It exemplifies how deeper reflections on theory drawn from multiple epistemologies can allow for novel theoretical and practical insights into the field of client treatment. This study recommends further and more expansive investigations into the possible uses of the preliminary philosophy drawn from the research undertaken.

This research is concerned with outlining a preliminary integrated philosophy for psychological wellbeing. Given the number of conflicting perspectives regarding the causes, treatments and beliefs of health, the author argues that South African mental healthcare is saturated with contradictory understandings of what underpins patient wellness. These incommensurable understandings conflict with new national health initiatives as well as possible difficulty in client treatment and referral. In an effort to reframe these understandings, the author posits that the use of the term 'well-being' allows for a renewed focus on the **individual being at the Centre** of mental healthcare.

Table of Content

Item **page**

Chapter 5

Chapter 7

Chapter: 8

List of Tables

List of Figures

Appendix

Chapter 1

The broader meaning of Well-being

1.1. Introduction

The dissertation will answer the following question: how can holistic wellness contribute to social welfare and health sector in South Africa?

A post-modem qualitative research will be carried out to establish the contribution of wellness to the social welfare and health sector in South Africa. It will also establish the road map on how holistic wellness can be integrated to both the social development and the health care system. The thesis will also have some elements of empirical research as data from existing clients will be utilized as work based evidence for the purposes of showing the contribution of all forms of wellness; physical, emotional/psychological, social, intellectual, spiritual, occupational, environmental, cultural, economic and climate wellness in order to enhance the total wellbeing.

1.2. The aim

The dissertation aims to provide, government, holistic and wellness practitioners with a manual that will assist in ensuring that the major role played by holistic approach. A manual will also provide a guideline on how to effectively use this model to help clients. This PhD will also explore the meaning of wellbeing within the spectrum of holistic approach, integrated medicine and wellness counselling in a broader sense.

1.3. Methodology

As stated earlier, This research lends itself to the postmodern qualitative method, that is, research essentially about obtaining data in formats such as case studies, narratives, artefacts, and interviews as well as other methods of obtaining research data that are not necessarily quantifiable (Busha & Harter, 1980; Creswell, 2007a; 2007b, Dey, 1993). This is demonstrated in the study's use of Delphi questionnaires and grounded theory and to inform its investigation into wellbeing.

As the research methodology is informed by grounded theory (Birks & Mills, 2011; Wasserman, Clair & Wilson, 2009; Fendt & Sachs, 2007; Tummers & Karsten, 2012), it highlights the researchers' own experience as well as self-reflection. The research presented builds upon established principles in wellbeing and consciousness and uses a grounded theory approach to allow critical inquiry into already well-established wellness or wellbeing concepts. This critical interpretive inquiry is

necessary in order to delve more deeply into the critical links between how wellbeing has been conceptualised and more importantly, how the screening method produced through this research can develop an understanding of wellbeing for the present.

Drawing from the data collection, coding, and categorisation, grounded theory is used to formulate and construct an understanding of wellbeing that draws upon previous conceptualisations as well as data collected in the study itself. This research can therefore be viewed as a form of metatheory, that is, a critical examination (or analysis) of related theories, thus providing a philosophical discussion of the foundations, structure, or results of these theories (Terre Blanche, Durrheim, & Painter, 2006) with the end result of this research being the development of a new, integrated wellbeing screening method.

As this research is a theory building exercise, and the method advocated is not tested or applied; validity and reliability are not germane. However, the researcher provides insight into how an integrated wellbeing screening method has been incorporated into his clinical intervention methodology, as well as some interesting case studies (evidence-based practice) (see Chapter 8; Macmillan & Shumacher, 2010).

1.3.1. Methods and Techniques for Data Collection

Research methodologies grounded within postmodernism embrace the notion of multiple avenues of inquiry into social phenomena. These multiple avenues of inquiry have the "additional advantage [of empowering] a variety of heretofore muted speakers to join discussions about social issues, legitimating them into the scientific field and depriveleging the mainstream positivist voice" (Agger, 1991, p. 121). This aids this study's aim to develop an integrated well-being philosophy for a conceptualisation of wellbeing and in turn, a screening procedure that accounts for not only previous wellbeing conceptualisations, as well as how counsellors and the researcher view this concept.

Grounded theory makes use of the postmodernist emphasis on multiple avenues of inquiry in generating theory (Wasserman, Clair & Wilson, 2009; Fendt & Sachs, 2007; Tummers & Karsten, 2012). More specifically, it is used for the generation of theory, which moves beyond simple description to one with explanatory power (Birks & Mill, 2011; Wasserman, Clair, & Wilson, 2009; Fendt & Sachs, 2007; Tummers & Karsten, 2012). In turn, it entails the need for a research method that possesses the ability to capture data from a wide range of contexts, perspectives, and timeframes in order to yield a comprehensive view of the phenomena under investigation (Birks & Mill, 2011; Wasserman, Clair, & Wilson, 2009; Fendt & Sachs, 2007; Tummers & Karsten, 2012). Thus, this research makes use of multiple data collection and analysis instruments such as survey research and case studies to further aid the development of a grounded theory approach to what would constitute a wellbeing method.

The benefit of grounded theory lies in the establishment of categories drawn from previous data sampling techniques in the construction of categories, allowing direction for further category clarification until they are fully developed or saturated (Tummers & Karsten, 2012). This technique known as theoretical sampling was used in developing this study's screening method.

Three main sources for data collection were employed. Firstly, a pilot survey that took account of the issues that South African counsellors face in screening for a client's wellbeing. Following this, the researcher undertook a literature review to establish the initial categories of previous wellbeing concepts, specifically the essential unifying threads between the fields of wellness and psychological perspectives. Based on this, a questionnaire informed by the Delphi-Technique was presented to a diverse group of counsellors to further clarify the initial categories outlined in the literature review, while case study research was simultaneously conducted to establish the worth of these categories for their application to a screening method.

1.3.2. Delphi technique informed questionnaire.

Following the establishment of the categories of virtues discovered during the literature review, the Delphi technique was used as a constructive method to facilitate controlled rationale communication to develop knowledge on how wellbeing is constructed by South African counsellors. The Delphi Technique makes use of identification and expert opinion in the development and further clarification of categories (Rowe & Wright, 1999). There are four prerequisite steps inherent in the Delphi Technique: anonymity, iteration, controlled freedback, and the statistical aggregation of group response (Rowe & Wright, 1999).

After the careful selection of the expert panel (see Sampling) and the construction by the panel of an initial open-ended questionnaire on what each virtue would entail, several rounds of iteration and clarification of the categories ensued. Controlled feedback was facilitated following the researcher's initial aggregation of the group response and a further cycle of questionnaires and grading of the responses took place. This was performed until full consensus and saturation occurred. The use of an expert panel and structured procedure facilitates greater reliability and comparison as discussed by Rowe and Wright (1999) who found that the use of unknowledgeable panels and unstructured procedures greatly affected the reliability of the Delphi Technique in studies.

1.3.3. Case studies: Exploration of the use of a virtue-based screening philosophy.

An initial exploration of multiple case studies was used to assess the value of a virtue-based screening philosophy for wellbeing. The use of case studies is used to [investigate] a contemporary phenomenon in depth within its real-life context… [which uses multiple sources to cope] with the technically distinctive situation in which there will be many more variables of interest than data points… [and lastly, is guided by the] prior development of theoretical propositions to guide data collection and analysis (Yin, 2009, p.18).

All cases drawn upon were investigated within the context of clinical interviews, and multiple cases were drawn upon to distinguish and elucidate multiple interest points to guide the data collection process. The cases that were selected depended on client agreement (see sampling in section 2.5 and ethical considerations in section 2.4) and the adherence to the exploration of the initial screening philosophy to aid their treatment.

In accordance with Yin's (2009) case study design, the research questions initially prompted the selection of cases, and thereafter investigation and subsequent screening ensued. Two types of investigation were utilised. The first of these was a general review of consensus of each patient's diagnosis with other screening procedures. Subsequently, two of the researcher's patients were selected for an in-depth screening procedure that used a virtues-based understanding of wellbeing in the treatment; therafter the case studies were analysed. This allowed for preliminary insight into the possible advantages that a virtues-based screening method would have in accordance with other clinical measures while aligning the said method with the research paradigm of taking into account multiple perspectives during the analysis and investigation.

1.3.4. Ethical Considerations

Prior to the commencement of this research study, permission was sought and obtained from counsellors, and clients who agreed to participate in this study. All the participants were given a written and informed consent form detailing their voluntary choice to participate and that withdrawal was an option at any time. Their anonymity was explicitly guaranteed and they were reassured that they would not be adversely affected.

1.4. Background of Well-being: literature review

Holistic wellness, as a lifestyle concept and an approach to overall health, has become increasingly popular. The phrase can be used in a range of contexts and encompasses numerous alternative health practices, so it can mean a variety of things.

Essentially, holistic wellness is an approach to physical, mental, and spiritual health that considers the whole person in the pursuit of health, happiness, and spiritual wellness.

It is often used to describe the overarching approach of many alternative or complementary medicine disciplines as well as a general approach to living a healthy, full life.

Instead of simply looking at specific issues, whether they are health complaints like a chronic or acute illness, lifestyle issues such as diet, exercise, or weight gain, a holistic approach to wellness takes every aspect of a person's life into account in order to find a place of healing, balance, and positive energy.

In this guide to holistic wellness, we will explore what a holistic approach to wellness truly is, why it's important, and how you can work towards achieving it.

The literature review has established that there is a misunderstanding on the concept of wellbeing. With regard to clarity of the concepts, Hermsen (2007, p. 149) and others found that a clear understanding of the concepts. The literature review also established that there is a need to train and educate wellness practitioners for ensuring that they can be ethically consistent and able to care for their clients on wellness. A complete and clear assessment is important in professional practice when using wellness approach with clients, this will aid practitioners to understand their clients holistically so that clients can be engaged in a harmonious way and avoid the possibility of violating their belief, practices and traditions. (Eck, 2002, p. 269).

Such formulations of the individual strongly contrast with the move towards post-modern thought, which argues for the need to account for a constructivist, interactionist view of reality. This paradigm argues that 'mechanisms of disease' do not adequately suit current understandings of how individuals and society operate between and within each other (Seley,1980). As such, post-modern approaches to health stress the need to move towards the term dis-ease. This move argues against the notion of diagnosing what is wrong with patients to what is right with them (Seligman, 2000). In so doing, it advocates the need for a better understanding of what well-being is (Ryan & Deci, 2001) and the need to differentiate it from the term wellness.

Research into wellbeing stresses the links between interacting inter- and intra-psychological systems in which the individual is engaged (Ryan & Deci, 2001), while placing the individual at the forefront of research inquiry. For the researcher, research into wellbeing further stipulates a move wherein subjects and patients are not singularly diagnosed or understood in terms of their malfunction. In this sense, an amputee such as Natalie du Toit, who is biomedically defined as being disabled can still be a 'being' who is 'well' — a 'well-being'.

This bears particular relevance to the National Health Initiative (NHI) in South Africa, which stresses prevention and the focus on developing wellbeing from the grass-roots level, which has historically suffered and still is suffering from being severely under resourced in health and education (Kleinert, & Richard Horton). Thus, there is a need to develop procedures which cannot only integrate multiple treatments and beliefs about wellbeing but could also aid new counsellors or health practitioners in facilitating their clientele's movement towards maintaining their health.

The development of such procedures resounds with the call for the development of other wellness measures which could improve medical and quality care outcomes (Holden & Kolander, 1992; Ragheb, 1993; Ryff & Keyes, 1995). One such area is the prevalence of mood and anxiety disorders (Stewart et al., 2003) in which research in the South African population reveals parallel findings with the rest of the world (STATSSA, 1996; Tomlinson *et al*., 2009).

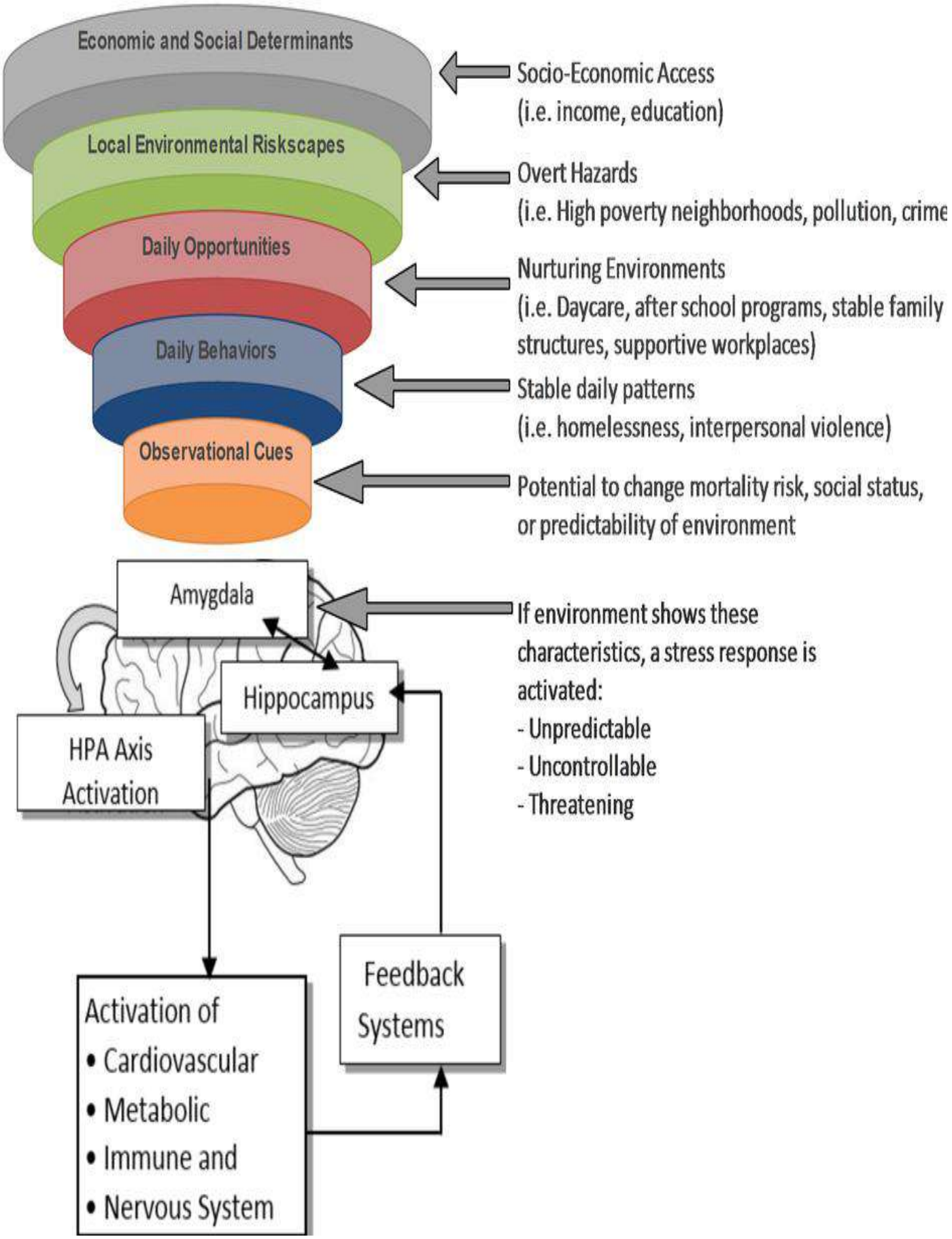
In response to the aforesaid, this dissertation stipulates the need to adopt an integrated approach towards wellbeing, informed by multiple perspectives that are woven together through an understanding of consciousness as a determining factor in mental and physical phenomena (Goswami, 1995). In particular, such an approach is needed in the development of a screening method that could potentially aid counsellors and other health practitioners to screen for distressing patient pathologies such as mood and anxiety disorders in order to ensure appropriate referral. In so doing, this dissertation hopes to aid the renewed focus of the NHI on 'healthcare for all', as well as safeguarding the health of the patients. In order to fully accomplish these goals, such an approach calls for a screening method that takes into account the debilitating effects of 'labelling' (Szasz, 1974). More importantly, the aforesaid calls for the development of an integrated wellbeing screening method, a method which aims to create quality procedures that underscore the need for clients to understand their own place and responsibility of moving towards their own wellbeing.

wellness graduate programs in counselling are lacking and this needs to be addressed especially when it comes to preparing wellness health practitioners students to engage clients in sharing their religious and spiritual concerns, and values (Eck, 2002, p. 269). Eck asked further suggest that clients are often uncomfortable when it comes to sharing about their spiritual and religious values when attending to them. Health practitioners also afraid to explore the area of spirituality.

Souza (2002) established that most health practitioners' students were uncomfortable when dealing with spiritual issues in counselling, this is due to fearing offending or of being judged personally. Students' opinions differ on whether they view spirituality as negative or positive, based on their own personal experiences with spirituality, and this work negatively in moving forward with the clear understanding on how spiritual counselling should be included (Souza, 2002, p. 214).

Figure 1.9.2.2.1.

https://www.healthandenvironment.org/assets/components/phpthumbof/cache/PsychosocialSEMModelLWalker.879ec1aa144148ce69d926a7c6213cd4.png


Economic and Social Determinants
Local Environmental Riskscapes
Daily Opportunities
Daily Behaviors
Observational Cues
Socio-Economic Access
(i.e. income, education)
Overt Hazards
(i.e. High poverty neighborhoods, pollution, crime
Nurturing Environments
(i.e. Daycare, after school programs, stable family structures, supportive workplaces)
Stable daily patterns
(i.e. homelessness, interpersonal violence)
Potential to change mortality risk, social status, or predictability of environment
Amygdala
Hippocampus
HPA Axis Activation
If environment shows these characteristics, a stress response is activated:
- Unpredictable
- Uncontrollable
- Threatening
Feedback Systems
Activation of
• Cardiovascular
• Metabolic
• Immune and
• Nervous System

A person diagnosed with any of the mental disorders has to experience an impairment societal, relationship and work adjustment. Psychological disorders present a social and humanitarian problem. If people are unable to function optimally and be productive in all spheres of their lives (e.g., employment, and other societal spheres) it is ultimately understood that these places a "burden" on the entire economy of the country and on the already stretched health professions. As Nevid *et al*. (2011) state, the severest form is the category of schizophrenia and

related disorders, as they generally require medication and/or hospitalisation. However, it is the category of mood disorders that probably has the greatest impact on capacity to function optimally (i.e., wellbeing) due to its sheer prevalence. The prevalence of lifetime depression (in USA) for men is 12 %, and for women it is 21 %; thus 16.5 % overall (Conway *et al*., 2006, as cited by Nevid *et al*., 2011). Stewart *et al*. (2003) state that depression is now a public health problem and the economic costs are enormous – the figure runs into billions in lost productive work time (as cited by Nevid *et al*., 2011). Pratt and Brody (2008) found that nearly 80 % of people with moderate or severe depression report difficulties with home, family, social, and work activities (as cited by Nevid *et al.,* 2011).

The 1996 Census in South Africa (STATSSA, 1996) indicated that 13 % of the adult working population suffers from major depression/traumatic stress. Tomlinson *et al*. (2009), in their survey conducted in South Africa, found that 9.7 % suffered from lifetime major depression while 4.9 % of the sample had experienced depression for 12 months prior to the interview. They also found that the prevalence of depression was significantly higher amongst females than amongst males, thus concurring with findings in the USA. Of particular importance to South Africa is that the prevalence is higher among those with a low level of education, and that more than 90 % of all the respondents with depression reported global role impairment (Tomlinson *et al.,* 2009).

The DSM-IV-TR classification system is important, specifically due to its pervasiveness within the medical community; yet by linking an Axis I disorder to an individual's Axis-IV lifestyle issues, labelling of the individual occurs (Seligman, 2000; Szasz, 1974). With this stance, not only is a person diagnosed as a 'socially incompatible schizophrenic', but by the links that the DSM-IV draws through Axis-IV to the economy, the individual also becomes "economically incompatible" (Seligman, 2000; Szasz, 1974). This labelling carries a debilitating effect (Doherty, 1975; Rosenfield, 1997) as the diagnosis carries a stigma accorded to the individual and in turn the extent of their own role in creating their own wellness (Seligman, 2000). This consequence of classification, while necessary to aid the treatment of mental disorders, must be carefully framed in how patients understand their diagnosis and further treatment in regard to *facilitating* an individual's well-being. The problem of classification in developing wellness argues the need for looking towards other models in understanding the treatment of disease such as the "positive" approach (Dunn, 1959; Seligman & Csikszentmihalyi, 2000). A positive approach towards understanding disease focuses on what is "right" with the client, and how to improve their integrated functioning in society (wellbeing), rather than what is wrong with the client (Seligman, 2000). This positive perspective in understanding wellbeing has long been associated with how counsellors engage with client wellbeing (Seligman, 2000).

1.5. **Counsellors and counselling in South Africa (background) .**

The primary role of a counsellor is to help clients adjust to the changing nature of their lives. It is furthermore empowering them with choices for positive, healthy, and adaptive psychological functioning (Loman, 1996). Counsellors are therefore concerned with psychopathological disorders, that is, disruptive dysfunction in one or more areas of behaviour such as cognitive, emotional, social, and biological, and their etiology (Campbell & Cellini, 1981, Coetzee & Cilliers, 2001). The South African College of Applied Psychology (2011) explains the role of the counsellor as understanding the emotional and behavioural attributes of individuals and families to deliver effective interventions within the multi-cultural context of South Africa. Therefore, counsellors within South Africa are legally allowed to perform assessments, measure psychological functions and refer clients requiring more advanced assessments to appropriate professionals (Government Gazette, No R. 704, 2011). However, a multitude of studies have suggested that counsellors suffer from information overload in situating themselves within the multitude of the often conflicting theories of wellness or wellbeing that consequently impact their self-confidence in assessing the wellbeing of their clients and in suggesting specific therapeutic interventions (see Lenz, Sangganjanavanich, Balkin, Oliver, & Smith, 2012; Roach & Young, 2007; Smith, Robinson, & Young, 2007).

Similarly, it has been the researcher's experience that newly trained professionals in South Africa (whom he has extensively mentored and worked alongside) also struggle to effectively evaluate and refer clients who experience extreme distress. To further explore this, the researcher conducted a pilot survey to assess the problems that South African counsellors face[1]. The survey resounded with previous research and the author's own concerns, suggesting that counsellors experience conflict about wellness theories as well as developing strategies to promote their client's wellbeing. More importantly, the survey illustrated that the counsellors themselves felt they had experienced some difficulty in screening for mood and anxiety disorders and effectively referring them.

In this light, it appears that while counsellors possess a unique understanding of approaching and treating individuals with anxiety or mood disorders, counsellors themselves struggle to situate their own practice within fields of wellbeing. This situation stipulates the need for the creation of a new screening method which can integrate psychological diagnostic criteria for severe distress as well as understandings drawn from wellness or wellbeing models. This suggests the need for the development of a study which is based upon novelty integrating past and contemporary models of wellness or wellbeing into an easily accessible framework for counsellors and clientele, and which facilitates positivist understandings of wellbeing and "dis-ease".

1.6. **Embracing global and local trends in well-being (background).**

The World Health Organisation describes health as "a state of complete physical, mental, and social well-being" (WHO, 2011; Tomlinson, Rudan, Saxena, Swartz, Tsai, & Patel, 2009), with wellbeing or wellness currently accepted as the optimal integration of mind, body, and spirit or soul (Seligman, 1975, 1991, 1993, 1996, 2002, 2004, 2011; Myers, Sweeney, & Witmer, 1998; Keyes, 2002; Hattie, Myers, & Sweeney, 2004; Snyder, Lopez, & Pedrotti, 2011). The global trend towards wellbeing has been appropriated locally with the move towards implementing the

New National Health Initiative (NHI) in South Africa (NHI policy paper from the Department of Health 2011) placing “well-being” in the forefront of current research initiatives.

This is a considerable task, as many researchers investigating well-being lament that due to it being studied across a wide range of disciplines and paradigms including the difficulty of establishing reliability, this has resulted in a lack of clarity with regards to wellbeing (De Chavez, 2005). It is thus understandable why South African counsellors experience difficulty in situating themselves within their field and treating clientele, as they often work between multiple, and sometimes incommensurable understandings about well-being (De Chavez *et e.l*. 2005).

This research looks at these incommensurable understandings and establishes that wellbeing is best viewed separate from wellness in that it places the interpersonal and intrapersonal interaction between the individual’s perceived reality and themselves at the forefront. In effect, this research elaborates on the need to establish an integrated philosophy of wellbeing using both established and controversial understandings of wellbeing.

The use of both orthodox and contemporary understandings of wellbeing research to facilitate the creation of a novel screening method suggests the need to use a grounded-theoretical approach (Birks & Mills, 2011). In turn, the creation of a new method with which to approach wellbeing calls for a consideration of controversial as well as established understandings (see Hattie *et al*. 2004; Keyes, 2002a, Lowman, 1996; Meyers *et al.,* 1998; Seligman, 1975, 1996, 2002, 2004, 2011; Snyder *et al*., 2011) as all the approaches could hold invaluable understandings to inform an integrative conceptualisation of wellbeing.

The researcher asserts that the integration of these new perspectives of the relationships between individuals, their environment, and their psychological being radically alter understandings of exactly how and why the dimensions of mind, body, and consciousness are integrated. This suggests noteworthy preliminary insights in developing a theoretical framework for the creation of an integrated screening philosophy.

1.7. Research Questions

1.7.1. What would constitute an integrated understanding of wellbeing?

- What similarities exist in the understanding between various psychological disciplines of the concept of wellbeing and wellness?
- What similarities exist in previous wellness models regarding the construction of wellness?
- How could an integrated understanding of wellbeing be informed from other scientific paradigms?

1.7.2. What is the role of wellness counsellors in the social welfare?

- How can wellness orientated holistic counselling approach fit into this inter-sectoral structure that government wants to implement?
- What is the role of wellness counselling in the social services industry, and how could the wellness counselling be expanded to include wider social services roles and perhaps qualify for subsidies?
- What kind of input and participation can wellness counsellors can provide in governance and representation structures?
- Which legislations are related to the Wellness Counselling context?

1.7.3. How can a similar understanding between various understandings of wellbeing inform the creation of screening procedures to inform counsellors and health practitioners?

- What aspects of previous wellness inventories and models can be used in developing a screening philosophy of wellbeing?
- What aspects of psychological perspectives of the understanding of mental health could inform the development of a wellbeing screening philosophy?
- In what ways could previous wellness strategies and psychological perspectives be drawn upon to inform the process of leading and pacing clients towards their own wellbeing?

1.7.4. Delineations and Limitations (Scope) of the Research

There are a number of limitations in this research. Firstly, this is a subjective synthesis of existing understandings of wellbeing. This can be viewed as problematic as it does not encompass all understandings of wellbeing and thus could be limited. This study is limited as knowledge is constantly expanding and developing. This synthesis of wellbeing is placed in time and drawn from current paradigms that the researcher has deemed to be the most enlightening in facilitating an understanding of wellbeing.

Secondly, this is a qualitative study, which emphasises subjectivity and small samples. There are a number of theorists who believe that qualitative studies are preliminary studies. In this frame of reference, this research can be viewed as a

genesis to conduct future quantitative studies or larger sampled qualitative studies informed by other methodologies.

1.7.5. Assumptions

- One of the main assumptions explained in social welfare is the idea that the inherent purpose of human existence is self-actualization. You believe that everyone has the right to achieve their highest potential, regardless of their background or class.
- There will be a gradual and continuing expansion of state responsibility for social provision with modest redistributive results.
- State-sponsored social policies can ameliorate the excesses and negative effects of the market economy by collectivizing the “social costs of private enterprise.”
- Every human being has to be considered as a person with dignity and worth.
- Human beings are interdependent and it governs their interaction in social groups.
- There are common human needs for growth and development of individuals. The existence of common needs does not negate the uniqueness of individuals.
- Every individual is like all other human beings in some aspects and like no other individuals in certain aspects.
- Every individual has within him/her, the potential for growth and achievement and he/she has a right to the realization of this potential. From this it follows that people has capacity to change.

1.8. Definition of Key Terms

1.8.1. Wellbeing versus wellness.

The author prefers the use of the term “wellbeing” as it implies a higher-order state with an emphasis upon the individual by the inclusion of being well. This nominalisation of the action to be well implies an active participation of the individual in the creation and facilitation of their own wellness, which echoes the author’s own understanding of wellness.
However, in the scientific literature, the terms ‘wellness’ and ‘wellbeing’ are used interchangeably. For instance, Johnson (2010) confusingly uses both terms in his understanding of the concept of wellness. In the literature review, the term used by the original researcher/s is stated to ensure clarity. When referring to the present researcher’s philosophy, the term “wellbeing” is used.

1.8.2. Integrated versus multidisciplinary.

The term multidisciplinary is not used as it may be perceived to convey the message that this model of wellbeing draws only on learnings from a variety of disciplines such as classic models of psychology and sub-disciplines (or specialised fields) within psychology (such as positive psychology, energy psychology, and transpersonal psychology) and from other disciplines (i.e., biology, neuroscience, epigenetics, and quantum physics). Rather than merely drawing from these multiple disciplines, the

philosophy that is developed incorporates and integrates these understandings into a synthesised understanding of wellbeing. As such, the term ‘integrative’ is used. Therefore, the researcher chooses to use the term ‘integrated’.

1.8.3. Social Welfare

Social Welfare can be defined both as a system and as an overall effort. This means that it can be designed as a systematic set of programs that assist the population in different stages of their lives but, that system comes from an effort and intention to provide that social welfare situation on the first place. Overall, social welfare means an ongoing attempt to take care of particular needs identified in the society.

1.8.4. Acts/Bill

An ACT is legislation passed by the Parliament. Acts can only be amended by another Act of Parliament. Acts set out the broad legal/policy principles. Acts of Parliament are formal documents which may seem difficult to understand, but you do not have to be a lawyer to understand how they work. Acts contain set elements and generally follow an established form. Acts of Parliament often give the executive, on the advice of the Cabinet and members of parliament, the right to make rules, regulations, by-laws and ordinances under a particular Act. These are called legislation and bills which must be consistent with the terms of the Act but they are not in the Act itself.

1.8.5. **RESEARCH PHILOSOPHY**

The research philosophy directs knowledge development through a structure of assumptions and perspectives consisting of the paradigm, ontology, epistemology and axiology (Easterby-Smith *et al.*, 2015; Fouché & Schurink, 2018; Saunders *et al*., 2016).

The research philosophy of this study is illustrated in a research onion framework in Figure 1.2 and discussed in more detail within the following sections under the categories of paradigm, ontology, epistemology and axiology.

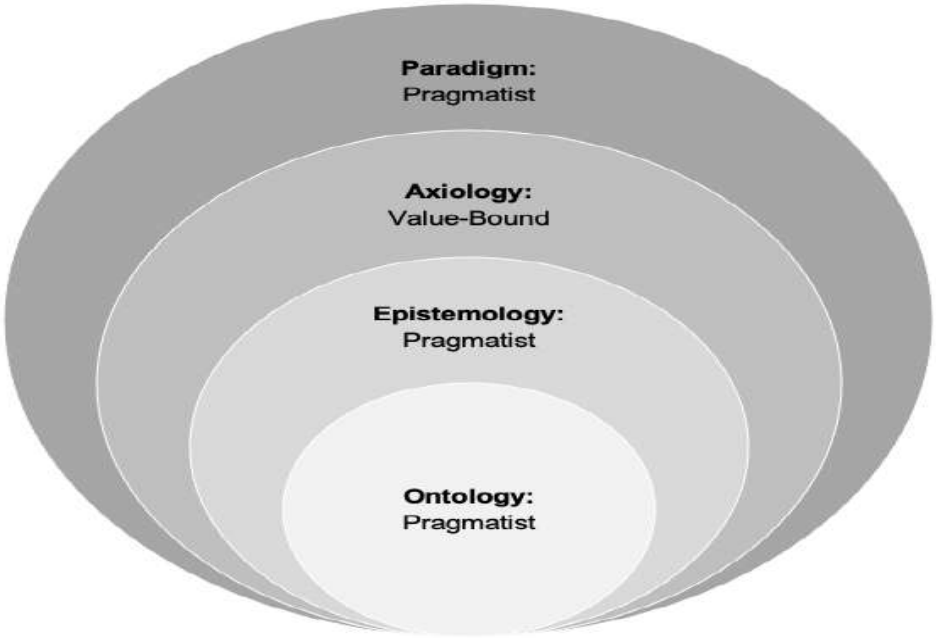


Figure 1.2: The Researcher's Philosophical Onion

Research paradigm

The research paradigm is that division of research philosophy that shapes a person's worldview; how the world is perceived from assumptions, interpretations and perspectives of reality, knowledge and values (Guba & Lincoln, 1994; Nieuwenhuis, 2017c; Saunders *et al.*, 2016).

The research paradigm for this study, was pragmatism.

The pragmatist paradigm has been chosen as the most appropriate for this study as it is a more holistic approach that integrates well with the interdisciplinary metatheoretical framework of this study while being ideal for use within a grounded theory mode of enquiry (Janse Van Rensburg, 2016). To fully comprehend the entrepreneurial mindset of and the reasons why Complementary Healthcare Professionals exit healthcare professions, the researcher believed that a pragmatic approach was the most appropriate to gain a general overview of the phenomenon in a complex South African context through a practical goal-orientated approach whereby personal perceptions and experiences could be understood without excluding any research methods in the process (Creswell, 2014; Shannon-Baker, 2016; Wium & Louw, 2018). Pragmatism made it possible to incorporate both or either of subjective and/or objective perspectives in this study, but from the researcher's dominant subjectivist position (Creswell, 2014; Dudovskiy, 2018; Ivankova *et al.*, 2017; Saunders *et al.*, 2016; Wium & Louw, 2018).

Before choosing pragmatism as the most appropriate paradigm for this study, the researcher considered the five main philosophical paradigms as presented in Table 1.2.

Table 1.1: Philosophical Paradigms (Creswell, 2014; Guba & Lincoln, 1994; Jansen, 2017a; Nieuwenhuis, 2017c; Saunders *et al.*, 2016; Sekaran & Bougie, 2013; Walliman, 2011)

Positivism	Positivism is a paradigm supporting objective truth that can be observed and scientifically justified while the supernatural (theology) and the abstract (metaphysics) are excluded as inferior to science.
Critical Realism	Critical realism is a paradigm of critical reasoning, acknowledging objective truth, but not as a result of observation and objective measurement alone, as interpretation of underlying historical insights are needed to understand the present situation.
Interpretivism	Interpretivism, also referred to as constructivism, is a paradigm supporting subjective truth based on the creation of meaning through personal experiences and perceptions within specific contexts, regardless of whether objective truth exists in the world.
Postmodernism	Postmodernism is a paradigm of multiplicity where various subjective opinions, perspectives, realities and viewpoints are valued instead of an expert's specific view, because language is seen as insufficient to effectively describe reality, knowledge, truth and meaning and these concepts are subsequently constantly challenged.
Pragmatism	Pragmatism is a paradigm of action with multiple realities; integrating objectivism and subjectivism while seeing truth as speculative, adaptable over time and what seems to be applicable in a specific context.

Table 1.2 summarises the different philosophical paradigms considered for this study, but an understanding of the researcher's worldview leads to an appreciation for pragmatism as the selected research paradigm of this study. A worldview is a person's ability to make sense of the world, based on certain assumptions that may stem from past experiences which may determine the absence or presence of a spiritual world (Callebaut, 1993; Herholdt, 1998a; Murphy, 1996; Scheepers, 2002; Schulz, Van Wijk & Jones, 2000; Tshotsho, 1994; Washburn, 1994; Waugh, 1999).

The researcher's Christian-holistic worldview is religious rather than secular; where religion signifies a conviction in a Supreme Being or God (Kumra & Manfredi, 2012) while secularism denies the existence of a Supreme Being and the spiritual realm (Blue, 1987). From this worldview, the researcher supports a holistic rather than a dualistic view as supported in Hebrew thinking where man is viewed as a unit and not as dualistic or trichotomy as is derived from Platonic philosophy (Atkinson, 2011). Holism may conceptually amount to a form of epistemology or functional monism, that perceive humans to be integrated or holistic wholes as a specific truth, instead of ontological monism, that perceive the world as the only object in existence (Atkinson, 2011; Cornell, 2013; König, 2011; Oakes, 1971). As the researcher supports holism, it is evident why the researcher has an interest in CAM and practices within the field of therapeutic reflexology as it can be seen as a holistic approach to healthcare (AHPCSA, 2014b, 2018c; Dougans, 2005; Du Plessis, 2012; Paterson & Britten, 2004; Shealy, 1999).

The researcher's worldview influences this study as it is believed that healthcare systems and Complementary Healthcare Professionals as human beings are to be viewed holistically,

meaning that all people are seen as unique individuals within a social context, even though they may be classified in different categories like temperament or personality. The researcher's Melancholic-Choleric temperament (Bhikha, 2006; Steiner, 2012) and Introverted-Intuitive-Thinking-Judging (INTJ) personality on the Myers-Briggs Type Indicator (MBTI) (Keirsey, 2019) indicates that he obtains information through a futuristic view and constant analysis while processing information by thinking about the facts within a sequential and structured manner while judging everything based on results and processes (Keirsey, 2019; Personality Max, 2019; Schneider & Prudhomme, 2014). People with an INTJ personality are naturally inclined to be pragmatic (Keirsey, 2019; Schneider & Prudhomme, 2014; Tilden, 2000).

The researcher tends to be pragmatic, especially in the sense of being focused on results and improvement of processes and systems with a compulsion for completion and meeting deadlines with an outlook on futuristic consequences and effects (Keirsey, 2019; Schneider & Prudhomme, 2014). Being pragmatic means the researcher believes that the best approach is the approach that works in the specific context and will provide the best possible results at the time (Atkinson, 2011; Schneider & Prudhomme, 2014). It is believed that even though a person fits into a specific personality type category, each person is still an individual within that category and does not necessary comply to all aspects within the personality type (Bregman, 2015; Formica, 2009; Wommack, 2014) and within that context, the researcher is pragmatic but with dominant weight placed on subjectivism due to the researcher's need to always fully understand different perspectives in order to comprehend a general overview of a situation or phenomenon.

The implication of making use of a more subjectivist dominance in pragmatism, rests in the fact that the researcher is not an independent observer, but involved in the research process, making it necessary to understand the researcher's ontological, epistemological and axiological positioning (Saunders *et al.*, 2016).

The next section will investigate the researcher's ontology in order to understand his reality and how it may influence the results of the study, followed by his epistemology and axiology.

1.8.6. Ontology

Ontology is the study or nature of reality, being or existence (Easterby-Smith *et al.*, 2015; Saunders *et al.*, 2016). The ontological position of the researcher determines how the nature of reality is perceived, especially regarding social phenomena like the entrepreneurial mindset and insights of Complementary Healthcare Professionals about decisions for exiting complementary healthcare professions and the healthcare industry.

The main ontological positions the researcher considered, are represented in Table 1.2.

Table 1.2: Ontological Positions (Atkinson, 2011; Dieronitou, 2014; Dudovskiy, 2018; Easterby-Smith *et al.*, 2015; Kaushik & Walsh, 2019; Mitchell, 2017; Nieuwenhuis, 2017c; Saunders *et al.*, 2016; Welman *et al.*, 2011; Wiid *et al.,* 2014)

Idealism	Idealism views reality as mentally created perceptions of the human mind that is always optimistically aspiring to philanthropic intentions as it is believed that people are concerned with the overall wellbeing of others.
Realism	Realism is an objectivist ontological approach where reality is perceived as singular and independent of social phenomena.
Relativism	Relativism is a subjectivist ontological approach that identifies multiple interpretations of reality as dependent on the interaction with and interpretation of social phenomena, viewing reality as socially constructed by individuals with different experiences, perspectives and understandings that are not necessarily concerned about the wellbeing of all people.
Pragmatism	Pragmatism views reality as multiple, dynamic and constantly changing based on individual interpretations within specific contexts that is relevant and leading to practical action.

Table 1.2 summarises the ontological positions from where it became apparent that this study is leaning towards a pragmatist ontology as a pragmatist paradigm suggests.

The ontological positioning for this study, was pragmatism.

Pragmatism was chosen as ontological position founded on the researcher's reality being shaped practically based on past experiences where it became clear that all people are not necessarily concerned about the wellbeing of others, although, from a Christian perspective there is a co-responsibility to take care of other people, resulting in a responsibility of stewardship. The reality experienced by Complementary Healthcare Professionals in the South African Healthcare Industry should therefore be considered from the various experiences, opinions and perspectives of the individuals attempting to succeed in specific contexts, namely private practices. The researcher's reality with regards to private practices in the South African Healthcare Industry has been shaped by the notion that people entering a healthcare profession, are doing so based on a calling and not merely as a profession, that emerged in a similar way to what Sefotho (2016) mentions as it originated in religion, emerged to psychology and progressed to holistic healthcare, although the underlying passion and calling to healthcare has always been present, but developed over the years as the researcher matured and his personal experience increased as his studies progressed from theology to counselling to complementary healthcare.

The researcher's view of reality is mainly based on personal experience and interpretation within specific contexts that are aligned with the ontological approach of pragmatism. This study was approached in a similar way from a practical ontological approach of pragmatism as it was believed that multiple realities existed amongst Complementary Healthcare Professionals that required understanding from the various experiences and perspectives of the different research participants (Dieronitou, 2014; Easterby-Smith *et al*., 2015; Wiid *et al.*, 2014). With the view of reality exposed as pragmatism, it is necessary to understand the researcher's epistemological approach in the next section.

1.8.7. Epistemology

Epistemology is the study or nature of truth and knowledge; the contemplation of thoughts and beliefs to understand the foundation of, and what is comprehended as adequate, truth and knowledge (Easterby-Smith *et al.*, 2015; Engelbrecht, 1998; Nieuwenhuis, 2017c; Saunders *et al.*, 2016). The epistemological position of the researcher determines what is seen as acceptable truth and knowledge, especially concerning phenomena being studied like the entrepreneurial mindsets and perceptions of Complementary Healthcare Professionals about employment, entrepreneurship and unemployment. The main epistemological positions the researcher considered, are represented in Table 3.4.

Table 1.3: Epistemological Positions (Dudovskiy, 2018; Easterby-Smith *et al.*, 2015; Gray, 2014; Johnson, 1995; Kaushik & Walsh, 2019; Kelly & Cordeiro, 2020; Klecun, Lichtner, Cornford & Petrakaki, 2014; Mitchell, 2017; Saunders *et al.*, 2016)

Objectivism	Truth and knowledge are seen as absolute and objective, discoverable through measurable and/or observable scientific methods and independent of individuals and the researcher.
Critical Realism	Truth and knowledge are seen as historical, or time specific, and temporary while it is difficult to obtain the complete truth as facts are socially constructed and open for interpretation based on experience and consciousness of different people at different times.
Subjectivism	Truth and knowledge are seen as flexible and subjective while being based on the personal experiences, opinions, perceptions and interpretations of individuals and the researcher. Two main subjectivist epistemological approaches can be identified as: **Nominalism (conventionalism)** is an extreme subjectivist view rejecting abstract objects and seeing social phenomena as created by the researcher and other individuals in their minds, based on the use of language and perceptions leading to multiple meanings of truth and knowledge in each individual's mind **Social Constructivism** is a less extreme view within subjectivism, acknowledging that truth and knowledge can exist outside a person's mind, but its meaning is in the consciousness and socially constructed, not discovered, through interaction.
Pragmatism	Truth and knowledge are seen as both objective and subjective, socially constructed based on individual experience and interpretations with accompanying consequences that is rational and can be empirically tested as it leads to action and the solving of practical problems in the real world within specific contexts, making it relevant in context.

Table 1.3 summarises the epistemological positions considered by the researcher, resulting in this study favouring the pragmatist epistemology where objective and subjective truth and knowledge are required to understand the various individual perspectives of Complementary Healthcare Professionals, regardless of whether objective and absolute truth exists in the world or not (Jansen, 2017a; Nieuwenhuis, 2017c; Saunders *et al.*, 2016; Sekaran & Bougie, 2013; Walliman, 2011). The existence or absence of objective truth and absolute truth is irrelevant in this study as it endeavours to understand the distinctive interpretations of truth and knowledge of the individual Complementary Healthcare Professionals. As human beings,

Complementary Healthcare Professionals create meanings from experiences within specific contexts and therefore pragmatism is the more appropriate epistemology in this study (Saunders *et al.*, 2016).

Pragmatism is compatible with the researcher's Christian-holistic worldview, especially regarding the congruence between a Christian worldview and science, particularly the emerging worldview of quantum physics that links the human mind and spirituality with science (Amarasingam, 2009; Atkinson, 2011; Sarkar, 2016; Walton, 2017). The pragmatist epistemological approach is more appropriate for this study as the researcher is aware that Complementary Healthcare Professionals have different experiences and interpretations due to interaction within the South Africa Healthcare Industry, leading to different meanings, truths and knowledge (Easterby-Smith, 2015; Meyer & Moore, 2015; Saunders *et al.*, 2016).

The epistemological positioning for this study, was pragmatism.

Pragmatism was chosen as epistemological position based on the researcher's truth and knowledge being practically created based on past experiences of interaction with phenomena like employment, entrepreneurship and unemployment. The truth and knowledge of Complementary Healthcare Professionals in the South African Healthcare Industry should thus be considered from their own individual experiences, and interpretation of experiences, that are constructed in their social interaction within the industry.

Pragmatism as epistemological positioning creates the ideal milieu to consider the Christian notion of stewardship as healthcare foundation; linking the epistemology with the pragmatist ontology where a responsibility of stewardship is apparent. Stewardship is an important function in healthcare systems, as the most successful healthcare models indicate (Fouche, 2011; Kapoor, Kumar & Thakur, 2014; Saltman & Rerroussier-Davis, 2000). Stewardship refers to the taking care of something that belongs to somebody else as Fouche (2011) rightly alleges to the possibility of stewardship in healthcare by adding emerging integrative healthcare systems into the industry. The researcher views stewardship as a responsibility of every person to not only take care of the natural environment, but also of other people and their wellbeing (Fouche, 2011; Kapoor *et al.*, 2014; Saltman & Ferroussier-Davis, 2000) while believing that an integrative healthcare framework is needed in the Allied Healthcare Sector to operate as stewardship model by giving back the responsibility of healthcare to every individual as every healthcare professional may take responsibility for their own health and for using their callings, gifts and talents effectively to assist with the wellbeing of others within such a healthcare system.

The researcher's truth and knowledge about employment opportunities in South Africa were developed within the secular perspective of earning income as being limited amidst growing employment equity demands in South Africa that excluded him from employment opportunities. Entrepreneurship became the obvious solution for survival, especially when entrepreneurship meant more to the researcher than merely earning income, but also as foundation for stewardship where providing a service and helping other people became more important leading to a paradigm shift in the researcher's view of truth and knowledge. The researcher's reality (ontology) displays a calling to help people within the healthcare industry, but the researcher's truth and knowledge (epistemology) is clouded by past experiences that a calling does not necessarily provides a sufficient income. The researcher's epistemology reveals that entrepreneurial proactiveness is a solution for unemployment through

employment creation but has certain challenges that need to be resolved in order for people to create their own employment instead of being dependent on employers.

Human beings acquire knowledge and truth about social phenomena based on their interpretation of events and experience within a specific context resulting in meaning creation about it (Saunders *et al.*, 2016). From this perspective it is noted that people may have different truths or knowledge about social phenomena, based on their own interpretation thereof rooted in their own experience. Understanding these various experiences and interpretations from Complementary Healthcare Professionals, may provide valuable insights into the South African Healthcare Industry in an attempt to answer the research problem while addressing the identified work-based challenge. The researcher's view of truth and knowledge is mainly based on personal experience and interpretation that are aligned with the more practical epistemological approach of pragmatism as the researcher intends to combine his personal experience and interpretations with those of the research participants in order to co-create an entrepreneurship framework.

Pragmatism is more applicable as epistemology for this study as is explained in the next section based on the researcher's own experiences in the South African Healthcare Industry, because the researcher did not propose to uncover any absolute truth, but instead to understand the individually interpreted experiences of the Complementary Healthcare Professionals in order to co-create an entrepreneurship framework that is relevant in the Allied Healthcare Sector.

With the view of truth and knowledge acknowledged as pragmatism, it is necessary to understand the researcher's axiological approach in the next section.

1.8.8. Axiology

Axiology is the study of the nature of values that may include aesthetics, ethics and religion (Dudovskiy, 2018; Killam, 2013; Saunders *et al.*, 2016). The axiological position of the researcher determines what is valued in the research, the way results are interpreted and the reasons behind decision making processes (Dudovskiy, 2018; Killam, 2013; Saunders *et al*., 2016; Smith, 2015; Zakus *et al*., 2007).

The main axiological approaches the researcher considered, are represented in Table 3.5.

Table 1.4: Axiological Approaches (Dudovskiy, 2018; Saunders *et al.*, 2016)

Value-free	The researcher is completely independent and detached from the research
Value-laden	The researcher is bias due to influence from worldview and personal experience
Value-bound	The researcher is reflexive and an integral part of the research

Table 1.4 lists the different axiological approaches, revealing that this study is leaning towards a more value-bound axiological position that can be seen as an appropriate subjectivist approach as opposed to a value-free position that is more relevant as an objectivist approach (Dudovskiy, 2018; Saunders *et al.*, 2016) and as opposed to a value-laden position due to the researcher being involved in the Allied Healthcare Sector of the South African Healthcare Industry, resulting in his integral involvement in the research process rather than merely being influenced by worldview and experiences (Dudovskiy, 2018; Saunders *et al.*, 2016).

The axiological positioning for this study, was value-bound.

Value-bound was chosen as axiological position based on the researcher's values being shaped subjectively while being intrinsically involved in the research and the South African Healthcare Industry where the biomedical model works well within the mainstream public healthcare system to deal with acute conditions, but a need exist for a wellbeing paradigm to address lifestyle conditions which is needed not only by the general public, but also in that the promotion of wellbeing may form part of the ecology of job creation in the healthcare industry.

The researcher's values can be described within the categories of aesthetics, ethics and religion. Aesthetically, what the researcher values as beauty in a person is when a calling has been discovered, followed by living a life of purpose while attempting to change the world or an industry for the better. Ethically, what the researcher values, is largely based on moral principles founded within a Christian-Holistic worldview where people are to be treated with love, dignity and respect in an attempt to edify instead of harming. The researcher believes that people are not truly valued and respected as convention dictates that within the mainstream public healthcare system their bodily needs and sometimes psychological needs are addressed, but to the exclusion of their spiritual needs and from a Christian-holistic perspective, the total multidimensional being should be considered, revealing the need of a holistic approach to wellbeing. Religiously, what the researcher values, is a personal relationship with God that results in helping people to live a holistically healthy life of purpose. What the researcher values and undertakes in this study, may be summarised as: (1) competence; (2) contribution; (3) development; (4) improvement; and (5) practicality. This study is an attempt of the researcher to explore the South African Healthcare Industry in an attempt to understand what Complementary Healthcare Professionals are experiencing in order to co-create an entrepreneurship framework in an effort to practically add value to the industry with the purpose of increasing viability of private practices in the midst of obvious challenges. The reason for the practical aspect linked to this study, is the researcher's endeavour to help Complementary Healthcare Professionals to have a choice whether to remain in or leave the South African Healthcare Industry instead of being forced to leave due to factors out of their control. The reasoning behind the research is considered in the following section.

1.9.1. Conclusion

A pilot study of South African counsellors' feelings of adequacy in screening for mood and anxiety disorders as well as facilitating client wellbeing revealed that counsellors experienced difficulty with effectively evaluating and referring clients who experienced extreme distress. This conflicts with the renewed focus, seen in the NHI and the WHO, which falls on the importance of allowing everyone access to their wellbeing. This is further compounded when reviewing the prevalence of mood and anxiety disorders in South Africa.

Therefore, this dissertation sets out to develop an integrated wellbeing screening method for the South African counselling profession.
In discussing models of wellbeing, Ryff and Keyes (1995) note the problem that "the absence of theory-based formulations of well-being is puzzling" (p.720). They further note the need for developing theoretical models, for testing the fit of such models with empirical data, and for conducting theory-guided structural analyses.
The development of comprehensive theoretical models requires a working elaboration of the concept of wellness, which informs the research problem of this investigation. Diener (1984) suggests that any such elaboration must include at least three components: It should be a) subjective, reflecting a concern for how the individual views themselves; it should include b) positive indices of an individual's sentiments towards life as opposed to negative ones (thus firmly situated within the arena of positive psychology); and it should be c) 'global' (in context) to encompass all areas of an individual's life. The development of an integrated screening method for wellbeing discussed herein attempts to reflect the concerns of both Diener (1984) and Ryff and Keyes (1995).
Ankrah (2002) expresses the negative effects for clients wanting to explore spiritual observation in counselling. He states that a client consulting counselling relationship who has experienced a spiritual or has been exposed to some kind of spiritual consciousness, is in danger of having their spiritual experiences misunderstood or not feeling free to expressed themselves and they end up keeping quiet (p. 58) Ankrah (2002).
Koenig (1996) emphasize that when religion is brought into a counsellor and client relationship, there is either a positive or negative effect which may be intensified. Spiritual counsellors need to train and educated to deal with effect including to encouraging clients to get to understand their faith and religious practice Koenig et al., 1996)

1.9.2. Chapters outline

1.9.2.1. Chapter 2: Literature Review

The Role of Consciousness in Wellbeing

This literature review chapter is concerned with developing answers towards three of the research questions, namely: What does wellbeing encompass? How can consciousness inform understandings of wellbeing? and lastly, what is the relationship between consciousness and wellbeing?

1.9.2.2. Chapter 3: Literature Review
An Integrated Well-Being Philosophy for the Counselling Profession

This chapter uses the clinical procedures outlined as a move towards illustrating an integrated philosophy of wellbeing that takes account of the myriad perspectives covered in previous sections. As such, this chapter is a discussion of the philosophy itself and how it should be utilised in a clinical setting

1.9.2.3. Chapter 4

The role of wellness in the social welfare

The objective and the extent of social work has been created to assist individuals in a community and bring changes to communities by creating strategies that seeks to help individual to have value in their society and by creating atmosphere of total wellbeing for marginalized individuals. This is achieved by uplifting the lives of the downtrodden in the society and transforms them to a place where they have dignity and self-love. This chapter deals with the role of wellness in the social welfare sector.

1.9.2.4. Chapter 5

Services and legislations related to social welfare in South Africa: Discussion.

In a country such as South Africa, an Act informs everyday life in a wide variety of ways and is reflected in numerous forms of law. For example, an Act provides guidelines on processes to follow before a law is passed; it also regulates how implementation of legislation has to be done, thereby giving authority and value to departments. In south Africa there are numerous acts which deals with a specific sector and the existence of this acts are designed to the purposes of development the lives of the citizens while protecting them at the same time.

The purpose of this chapter is to give brief functions of the different kinds of acts in South Africa; a special attention will be given to acts that deal with social works aspects for purposes of understanding them in the context of wellness counseling.

1.9.2.5. Chapter 6: Literature Review Wellness and Wellbeing: A Discussion of Empirical Models

As previously discussed, the incommensurability of healthcare as well as the difficulty that healthcare professionals experience in diagnosing and treating clientele calls for an *integrated* method to screen for wellbeing. This chapter looks at previous and contemporary models of wellness to outline the essential features that an integrated method would need to incorporate for counsellors to use when screening for mood and anxiety disorders. Understanding these movements and changes to wellness is important in developing novel approaches to conceptualising wellbeing, a key feature of explicating new theoretical insights in grounded-theory perspectives (Birks & Mill, 2011; Wasserman, Clair, & Wilson, 2009; Fendt & Sachs, 2007; Tummers & Karsten, 2012; Human & Du Plessis, 2007).

1.9.2.6. Chapter 7

Results and Discussions of Virtue-based Well-being

This chapter discusses the preliminary research carried out while developing, testing and implementing an integrated wellbeing philosophy for the wellness counselling profession. It thus deals with the research questions in developing the philosophy itself, wherein counsellors were asked to prepare positive and negative statements of what would evidence the nine virtues upon which the screening philosophy is based. Here, the researcher discusses the general views held by the counsellors in their understanding of virtues and utilises these understandings to develop the virtue-based model of wellbeing that underpins the philosophy.

1.9.2.7.Chapter: 8

The value of Traditional Medicine:

empirical discussion

The use of 'plant material' for the treatment of medical conditions, can be dated back more than 6 000 years in both Eastern and Western cultures (Gossell-Williams et al. (2006)). In China, there is evidence of authoritative publications designating the properties, action, use, dosage, and standards of strength as well as the purity of medicines as far back as the reign of Emperor Shen Nung, around 2730 - 3000 BC. These records have described the medicinal use of plants such as Hemp, Aconite, and Opium. The Egyptian Pharmacopoeia of Papyrus Ebers, dating back to about 1500 1550 BC provides evidence of the medical use of plant extracts such as that of Opium.

Chapter 9.
work based evidence at author's practice

Chapter 10

Conclusion and recommendations:(integrated approach) wellbeing, wellness counsellors in welfare sector and alternative medicine.

Chapter 2: Literature Review
The Role of Consciousness in Wellbeing

2.1. Introduction

This literature review chapter is concerned with developing answers towards three of the research questions, namely: What does wellbeing encompass? How can consciousness inform understandings of wellbeing? and lastly, what is the relationship between consciousness and wellbeing?

The author shifts focus to the very telling truth in Ecclesiastes that what has been understood and lost will always be understood again. This chapter is concerned with how consciousness plays an integral role in past and present understandings of wellbeing. In so doing, it instils the recurring theme within this dissertation of the importance of an integrated perspective in understanding wellbeing and the interventions used to ascertain it.

This recognition is fundamental as the wellbeing philosophy discussed draws heavily upon the notion of virtues. As stated previously, numerous wellbeing or wellness models have emphasised the relation between thoughts, emotions, and behaviour in informing the wellbeing of a person. This chapter is concerned with developing this connection more explicitly, stipulating the need to turn to consciousness, metaphysics, and quantum physics.

Wellbeing has long been caught within a liminal phase – it has been claimed by both paradigms of allopathic (mind/ body perspective) and alternative (mind-body perspective) medicine (Capra, 1976). These different valuing of wellbeing of these perspectives has meant that the term's meaning has become conflated with myriad different understandings and interpretations that provide neither a clear pathway to wellbeing nor the ability to find it "underneath the sun". This loss can be traced to the fundamental differences of both perspectives in understanding how consciousness and wellbeing relate to the body and what each perspective understands as the causative role of disease.

This chapter explores these misunderstandings using findings from quantum physics, which would provide routes to surmount the mind/body understandings of consciousness. It provides a basis for further exploration of how the lines separating different medical understandings are arbitrary as well as the possibility of choice between disease and wellbeing. In turn, it creates a space for recent controversial research in wellbeing to be explained in addition to offering a different client-patient relationship.

The author uses the aforesaid notion to argue that the underlying structure of wellbeing in terms of these alternative versus allopathic understandings of wellbeing, while seeming far removed from each other, are the same – they are "nothing new under the sun". In a postmodern frame, this rings true as multiple narratives and

understandings of the same phenomena are all true (Keddel. E, 2009). In this manner, quantum physics meta-theory provides a foundation or narrative for virtues upon which the author's philosophy of wellbeing is built.

2.2. Detailing Reality: A Well-Being Foundation in Quantum Physics

The focus of Ecclesiastes on the sun (or rather that there is nothing new "under" the sun) serves as a great starting point from which to delve into the space that quantum physics creates in informing an integrated philosophy of wellbeing, as it highlights the prejudices and paradoxes contained in historical understandings of consciousness and ways of being.

The sun, or rather light, is a quintessential element for life to occur; without it, life as it is currently understood, cannot thrive, produce, or reproduce. In this sense, the understanding of light constituted a fundamental question for Classical/ Newtonian science to answer. In the Newtonian tradition of science, matter is premised on the concept of continuity, meaning that that which an object is, is what the object will always be – waves continue to be waves and particles continue to be particles.

Light, in terms of the continuity principle, poses a problem in this regard, as Einstein discovered in the early twentieth century (Wendt, 2004; Hanson, 1959). In his experiments, light was observed to operate as both a particle and a wave, in turn demonstrating that within current scientific understandings, light was paradoxical as it was discontinuous. This type of paradox did not afford any place within Newtonian science as matter is determined, discrete, and specific. The universe and its components can be reduced to its smallest particles (atoms, electrons, protons, and neutrons) and these in turn cannot change and are the cause for the manner in which the universe reacts and acts.

Einstein's experiments of light in turn illuminated the adage of Ecclesiastes that "there is nothing new under the Sun" in Newtonian physics, as it turns out there was something new and paradoxical about the sun itself that had been explored previously in Eastern philosophy and ancient scripts. Quantum physics confronts these paradoxes head on by making space for paradox, and by changing its focus from the reduction, to the material, to the expansion of possibilities.

2.2.1. Downward causation: Illuminating inquiry into consciousness.

The focus of quantum physics falling on the expansion of possibilities rather than the reduction of materialism is premised on its understanding of how consciousness/ inquiry operates. Classical/ Newtonian/ materialistic scientific inquiry is premised on the materialistic quality of objects that gives rise to causation. The object is pre-determined in terms of its most basic elements which gives rise or cause to the manner in which it interacts with the basic elemental structure of other objects. Harald Walach and Hartman Rohmer (2000) note this inquiry as a worldview of 'bottom-up' or 'upward causation'.

Quantum physics, in its focus on possibilities, offers an inverse to the classical/ Newtonian/ materialistic worldview by arguing that it should rather be 'top-down' or 'downward causing'. It thus shifts the focus of the 'basic elemental object' in Newtonian science to the focus of 'consciousness' (Walach, & Rohmer, 2000).

This shift towards possibilities and consciousness has been premised on a number of studies, but originates with Max Planck (1900) who supplemented the original meaning of "quantity" with being a "discrete quantity" (Walach & Rohmer, 2000; The example used to fully illustrate this was a quantum of light, a photon, which is an indivisible discrete bundle of energy that cannot be measured or seen, but can be exchanged between one body and another. For example, the light energy exchanged between the sun and a plant is indivisible and discrete in that the plant cannot exchange the energy in a lower denomination than that which was sent (Stanford Encyclopaedia of Philosophy, 2008). A 'quantum' was thus the base energy of matter that is exchanged between objects.

Coinciding with this theorisation of quantum was Einstein's studies of light (referred to above), which observed that it could be seen as operating as a 'wave' and as a 'particle' (Norwood, Russell, & Hanson, 1959). In the basic energetic unit of light being able to be observed as a wave and as a particle, it cast doubt on the reductive nature of Newtonian understandings. It illustrates that basic elemental particles were not in the least basic, but rather, more infinitely complex and that they could be anything they were seen to be.

Bohr (1913) built upon Einstein's inquiry in his theorisation of the quanta of light electrons emitted around atoms (as cited by Goswami, 2013). He suggested that as electrons move from one atomic orbit, the discrete quantum of light energy emitted was not related to the continuous movement of the electron moving from one orbit to the lower, but rather, it was a discontinuous movement. The movement of the electrons could not be predicted nor did they move in a continuous pattern. Bohr denoted this as a quantum leap – a discontinuous movement of an electron that does not go through the intervening space (Stanford Encyclopaedia of Philosophy, 2008; McMullin, E., 1984).

In regard to the research of Einstein and Bohr on light, it suggested a number of contradictory notions to classical understandings of science. A photon of light possessed the potential to be everywhere and anything when observed it was immaterial and material at the same time: as it could spread out like a wave; appear in more than one place; move in 'discontinuity' or be localised at the same place with the same trajectory (Oliver Passon, 2006). Yet, the wave-particle duality was not only restricted to a photon of light, as de Broglie demonstrated, but that all matter could be observed as both 'particle' and 'wave' (Oliver Passon, 2012).

Matter, thus could not be explained according to orthodox scientific principles. This shifted the focus of certain scientists, the early pioneers of quantum physics, to engage with the idea of possibilities of how matter is observed, because its dual nature could not be adequately accounted for. In effect, it led to the theory of quantum waves which postulates that electrons or energy exist in many places at the

same time yet only in terms of the possibility what can be or could be observed (Stanford Encyclopaedia of Philosophy, 2008).

In this sense, a quantum is a wave with possibilities and as such is interconnected with probability (Arenhart, 2014). The probability of an event can be easily plotted when an average of large measurements is called upon; however, a problem exists when a single event or activity takes place as the probability for this is impossible to plot as a single event can have an infinite number of possibility(Arenhart, J.R.B., 2014). It locates that which is actually seen or observed is dependent upon who observes it – the notion of consciousness that something is here or there only when the individual discerns here or there. This wave with possibilities is localised when a quantum is measured, and results in the collapse of this wave with possibilities. This is described as observer effect in quantum physics (Bessinger, 1996; Radin, 2006).

The spreading of a quantum wave spreads not in space-time, but in the realm of possibility, a realm that Heisenberg called potential. The moment we observe and measure, the wave of possibility collapses and becomes localised in actuality as a space-time event. In the realm of possibility, the electron is not separate from us, from consciousness. It is a possibility of consciousness itself, a material possibility. According to Goswami (2012), when consciousness collapses, by choosing one of the electrons of the possibility wave, possible facets becomes actuality: The events of collapse of the waves of possibility are the results of conscious choice, downward causation. For this no mathematics exists, no algorithms. The choice of downward causation is free, unpredictable (Goswami, 2012).

This implies that individuals choose their own reality, in that through their choices downward causation occurs as a meaningful and potent force in quantum physics. In essence, it is our conscious actions through which all others occur; consciousness is the foundation of all being (Goswami, 2012).

The photon is a telling example as it illustrates how energy and the individual (as an observer) are interconnected. Through the lens of quantum physics one can only discern something if one chooses to discern it; the action triggers the reaction. Similarly, within the medical field this has been witnessed in the use of new technologies that take account of the mind's energy field to dictate the release and uptake of neuropeptides and neurotransmitters within the body, for example, electroencephalography (EEG); magneto-encephalography (MEG); and trans-cranial magnetic stimulation (TMS) (Lipton, 2001). These technologies are based on the principle that the brain generates and responds to energy fields that influence a person's behaviour, gene expression, perceptions, and mood through the mind's energy field itself. The individual's energy fields and those of their environment are interconnected.

The interconnection between matter, energy, and the person within quantum theory, and in turn downward causation, lead one to postulate several key considerations in understanding what constitutes consciousness in quantum physics.

2.2.2. Quantum nonlocality: A subtle interconnection of everything.

The placebo effect has been empirically well documented in myriad research studies (Moerman & Jones, 2002; Steward-Williams & Podd, 2004; Kaptchuk 2002). It relates to the power of a person's belief to orchestrate physiological changes despite the fact that this belief has no physiological evidence of causing physiological change. It has been a puzzling question for many researchers to answer and has remained largely unanswered.

However, quantum physics posits that the placebo effect can be explained through the principle of nonlocality, which assumes that when a quantum particle interacts (entangles) with another particle, they remain coupled no matter the distance between them. This was first hypothesised by Bell & Bohm (1952; Oliver Passon, 2006) and later shown empirically by Apsect (1982) when he demonstrated that two photons from the same calcium atom continued to react synchronically despite the increasing distance between them. **This suggests that the placebo effect refers to the nonlocal effect of the mind interacting with the body, where changed belief in the mind causes changed physiological change in the body.** Goswami took this a step further by advocating that "quantum nonlocality also happens between brains".

This principle bears an important connection in wellbeing, as the coupling between two quantum particles can be understood, especially between people as two "consciousnesses" colliding. However, Goswami (1995) emphasises that there are not two consciousnesses at work, but rather a "singular for which there is no plural" (p. 89).

By this Goswami (1995) argues that our notion of individuality is an illusory epiphenomenon of experience, as the nonlocality of particles demonstrates that participles do not randomly interconnect, no matter the distance. They are and have been always been intricately interconnected as they are part of the same whole. Jung deemed this to be synchronicity whereby a "meaningful coincidence [is] attributable to a common cause" (Wallach & Rohmer, 2000; Bessinger, 1996).

Two events occur at two completely supposedly unrelated places; but on closer examination, one finds a meaningful coincidence. Goswami also stresses that quantum nonlocality should not be considered to be an esoteric concept. Human beings live more in their heads than their bodies which therefore gives us a feeling of being alive. This feeling is unitary and not fragmented (only in certain parts of our bodies). This unity of experience is our phenomenon of quantum nonlocality.

The above phenomenon poses a problem for neurophysiologists as new technology, inter alia functional MR scans, makes it possible to observe the brain while meditating. In the brain's mediation of activity, several spatially separated brain areas accompany the individual's mental experiences (Holzel, et al., 2007). This confirms that people have a unity of experience – a picture perfect example of quantum nonlocality.

Relating this to the wellness or wellbeing models described previously, the principle of nonlocality provides an important facet in exploring the roles that virtues can play in addressing wellbeing. Nonlocality suggests that the mind, the body, matter, and energy are interconnected. In so doing, it argues a notion of consciousness that avoids the paradox of dualism (consciousness/ brain) as "consciousness chooses from itself…. [consciousness interacts with matter in] a signalless communication" (Goswami, 2011, p. 3; Bessinger, 1996). Thus, quantum physics makes space for the interrelation between beliefs, emotional states and behaviours as indicators and areas for possible change when screening people for wellbeing.

2.2.3. Tangled hierarchy: Who am I? And who are we?

Whilst the interconnection between all matter is emphasised in the nonlocality of consciousness, quantum physics also proposes an understanding of an individual's self-reference. As stated above, the properties of a photon and the energy that it emits is dependent on the observer. Thus: According to quantum rules, before measurement, before collapse, not only the object/stimulus but also the observer's brain itself, the brain that is taking in the stimulus, must be represented by a wave of possibilities (Goswami, 2011)

In turn, if the brain was not involved in the interaction, there would not be any awareness of the object under study, yet at the same time the interaction between the object and brain needs to collapse in order for a possibility to arise. Goswami (2011) refers to this as a circularity between interacting particles, as one cannot exist without the other, which is best understood when one looks at M.C. Esher's painting of two hands drawing each other.

When looking at the painting, it is difficult to discern which hand is drawing the other. As they illustrate circularity, the one constitutes the other, resulting in the subject and object co-creating the other. Yet, the individual looking at the paper can distinguish him or herself from the painting; the painting is the object being interpreted by the person (the subject) viewing it. This is understood to be self-reference.

However, the problem arises in the actual interaction between the person and the painting itself for they in turn constitute each other. If there were no viewer, there would be no painting to be viewed, and if there was no painting there would be viewer to view it. The subject and object in their interaction co-create the other and their interaction. However, they are so entangled in their constitution it is impossible to pinpoint (as in the Escher painting) which constitutes which. In quantum physics, this is understood to be 'tangled hierarchy'. This is the problem of individual experience, as our understanding of individualism which occurs as a result of tangled hierarchy is completely illusory, yet important, as it is the way consciousness identifies the brain.

In regard to wellbeing, tangled hierarchy and self-reference are important concepts to understand. Dysfunctional families, couples, and even doctor-patient relationships can produce much stress when they do not "act" as a unit, when it lacks a "self"

identity (Bandler, Grinder, & Satir, 1976). In healing, it is thus important that the doctor and the patient become a self-referential unit, where this unit has value. This stipulates a need for a philosophy to be theoretically drawn upon; one that causes the least amount of personal distress to the client and one in which the client and the counsellor can interact as a unit.

2.2.4. Discontinuity: Quantum leaping creative consciousness.

As outlined earlier, the Nielhs Böhr principle of discontinuous movement of electrons challenged the principle of continuity found in Newtonian physics. He explains that electrons go around the atomic nucleus in orbits, in more or less the same way as planets orbit the sun. This phenomenon is continuous movement.

However, at any time an electron can disappear from one anatomic orbit and appear in another without travelling between the intervening space between the two orbits. This jump is discontinuous in that it is not permanent or fixed in movement. In fact, the only continuity about how electrons orbit nuclei is that they are dynamic and unpredictable.

In consciously viewing an object, a subject's interaction must result in an actuality. This change of possibility change from to wave to actuality (as referred to above) is deemed to be a 'collapse'. The type of collapse a subject associates with a possibility can consist of an infinite number of actualities which no continuous algorithm can predict (Bessinger, 1996). Collapse in this sense is discontinuous and is a quantum leap in the experience of individuals in their day to day lives.

2.3. Detailing a Different Reality for Well-Being: Quantum Physics and Consciousness

Returning to the thought in Ecclesiastes at the beginning of this chapter, the author firstly noted the idea that there is "nothing new under the sun" to argue that there are new understandings within the realm of quantum physics that can lead to understandings of wellbeing that are different from those that were posited earlier. In effect, quantum physics, with its change of focus, can have: profound implications for our personal lives…. we are fundamentally energetic beings inextricably connected to the vast, dynamic energetic field we are part of, we can no longer view ourselves as powerless, isolated individuals who happen to have won the Darwinian evolution (Lipton,B., Bhaerman, S . 2010).

The author now turns to the first part of the maxim in Ecclesiastes: "What has been will be again, what has been done will be done again". While quantum physics can be seen to be a radical departure from the commonly taught understandings of Newtonian physics, the focus of quantum physics falls on energy, interconnectedness and 'freewill', which in turn correlates with much older understandings found in Eastern philosophy and mysticism that have been lost in contemporary scientific inquiry. By engaging in the possibilities of consciousness,

quantum physics has returned full circle and in so doing creates a space in science, and more importantly, wellbeing for the subtle concepts that have been left along the wayside of positivism and empiricism inquiry. It is to this that the author now turns.

2.4. Engaging Quantum Possibilities in Well-Being: Contemporary Spirituality

Considering matter to be possibilities within the consciousness of the individual allows an avenue to challenge the Cartesian dualism by turning to spiritual and contemporary thought (Bessinger, 1996; Curtis, & Hurtak, 2004).

One of the most engaging concepts that is pinned to this is the concept of gross and subtle bodies, which Goswami (2011) links to the five bodies of consciousness: the physical, the vital, the mental, the supramental, and the bliss, and Jungian personality traits (sensing-type, thinking-type, feeling-type, and intuitive type). The combination of these models leads to four worlds of possibilities: a world of physical possibilities wherein the subject *senses* collapse; the vital world where collapses are *felt*; a mental world of possibility that is centralised on the subject's *thought* of collapse; and the world of possibilities that collapses are *intuitive,* belonging to the supramental.

Goswami (2011) sees every individual nonlocally, inhabiting each of these bodies where consciousness acts as the mediating agent between them. The mind and body (the internal and external) are not separated in this line of thought, but are rather interactive and integrated in everyday experience of the individual's reality. Thus, while the physical body (the gross/ public body) is external and the vital-mental-supramental (the subtle body) are internal, both are accessed and affect the other in an individual's interaction with their environment.

This is clearly evident in regard to healing. While disease is often located in the physical/ public body of the individual, it can be assessed in terms of molecular biology. Healing, on the other hand, cannot be assessed as it relies on a nonmaterial element, a different type of energy, vitality (Curtis & Hurtak, 2004). Vitality is not chemical in constitution; rather, it is felt and this feeling of vitality can radically change the healing process. In this sense, the subtle world of the vital can affect the public or the gross in that it can shape and mould functions of the body to react to the physical world, for example, the feeling of fear or the feeling of love. Understanding love as a virtue, it appears that virtues affect the public and gross bodies; they find outward expression in people's behaviour and the way they think or believe.

Sheldrake (2011) likens the interaction between the vital and the physical body to that of a software program running on a computer's hard drive. In this sense, the vital body acts as the program that prescribes how the computer (the physical body) should react. Sheldrake (2011) relates this to the nonlocal and nonphysical morphogenetic fields that flow from the vital body to affect the physical body. These flows lead to cell differentiation at birth or the reactions to the feeling of vitality in

illness in aiding the healing process. In essence, the consciousness of the individual using vital blueprints leads to physical representations of the vital functions that become codified in the supramental body. Thus, when consciousness collapses in the physical body (an organ conducts a function) this leads to a collapse of the vital body (a feeling of vitality/ cell designation) (Goswami, 2011).

Reflections of this is echoed in Eastern philosophy in its conceptualisation of the role chakra and or prana plays in the healing process (Curtis & Hurtak, 2004). These energy fields interact with the subject's feeling and awareness of themselves as the emotions that are felt internally. Related to this quantum physics, the morphogenetic fields of the vital interact with that which is felt by the person (emotion), how it is felt by them (vital), and where it is felt (physical) (Curtis et al., 2004).

Research conducted by Pert (1997) on the interaction between molecules and emotions clarifies this to a great extent when considering the emotion of pleasure. When the emotion is felt, it results in the release of endorphins or the inverse could be said to be true. Pert discovered that the internal cell constitution can change when emotions are felt, displaying the power of prana or hakra or the vital body and how consciousness interacts with the gross and subtle bodies of the person.

Morphogenetic fields add to the role that chakra plays in emotions. Chakras relay the idea that certain energetic fields originate from certain centres with regard to the emotions they feel. These centres constitute areas of access to the vital body that interact with the physical body. They are the source or origin of energy.

Combining the model of logical levels created by Dilts et al (1996) and incorporating it within the notion of chakra locations, an intriguing parallel is revealed. Dilts et al (1996) state that people move between a hierarchy of environment and spirituality; similarly, chakras move down from the crown (where spirituality is located) towards the ground chakra (where the environment is located). Dilts and Eastern philosophy both hold that the *environment or ground chakra* influences people's *behaviour or stomach chakra,* which bears notions of capabilities of feelings or thoughts to the beliefs where the heart chakra is located. *Identity and the head chakra* correspond to the way in which people believe ideas of themselves, which in turn influences the *crown chakra or a person's spirituality or virtues.*

In this sense, the bliss body is connected to the environment through a hierarchical frame that shows the interrelationship between aspects of the self and energy flowing through the body. Einstein echoed this in his statement "[that one] cannot solve a problem on the same level you created it" (Covey, 1992) p.42). This resounds the quantum physics meta-theory of tangled hierarchy, wherein both the consciousness of environment or belief and the different chakra areas are collapsing points for self-reference. In turn, it illustrates deeper connections between beliefs and energy, consciousness and body, and feelings and the endocrine systems. It also suggests that the logical level model of Dilts et.al (1996) as well as Eastern philosophy share common assumptions on how energy or beliefs are spread throughout individual consciousness and the body respectively.

2.5. Quantum Understandings of Consciousness used within the wider ambit of wellness

2.5.1. Introduction.

The significance of consciousness and its interaction with an individual's virtues recognises the importance of how information flows through the body in understanding wellbeing. This perspective on health allows an understanding of the importance of the role of external factors (psychological, socio-economic, and environmental) in our conceptualisation of illness. These insights shift the focus onto wellbeing and the 'functioning body' rather than the 'ill and malfunctioning body', illustrating how deeply the mind, body, and consciousness are intimately linked and operate in unison. In this section, the researcher presents contemporary research that uses understandings from quantum physics in theorising wellbeing.

As previously discussed, the lifestyle choices people make place them on the continuum between 'dis-ease' and 'well-being'. Furthermore, from a non-materialistic viewpoint, physiological changes correspond with a person's wider environment and their interaction with it with regards to: their life; creative expression and freedom; spiritual connectedness; financial situation; sex life; lifestyle; and mental and emotion stability.

These aspects of wellbeing affect a person's interaction with their environment in that they cause either a 'stress' response or a 'relaxation' response. These responses correspond to the 'principles' of wellbeing described in positive and transcendental psychology as well as in the theories of wellbeing of Strumpfer, Coetzee, & Cilliers; and Adams et al. For example, positive virtues such as joy and hope turn the relaxation response on, while negative emotions such as judgement and fear trigger the stress response. Both negative and positive emotions then cause physiological reactions.

2.5.2. The physiology of emotion.

The key to the physiology of emotion is to discuss how thoughts or feelings translate to physical effects on the body. The works of Lipton (2008), Dilts, Halbom, & Smith (1990), and Pert (1997) have all been drawn upon previously to show how thoughts, feelings, and beliefs intersect with the physical body. Goswami (2011) explains the physiological effects of thoughts and feelings due to the power of consciousness to create and manifest effects on the body. This displaces the idea of thoughts and feelings as mystical aspects of being human but instead stresses the material and non-material world being inevitably intertwined – entangled hierarchy.

To lay further claim to the discussion of Lipton, Dilts et al, and Pert a further demystification of the effects of thoughts and feelings on the body has also been

established in evidence-based studies that establish emotion as being physiologically based. This is seen in the reptile brain (located near the brainstem) which accommodates the hypothalamus that cannot distinguish between an abstract thought of fear and a real-life survival threat. When the reptile brain detects a threat, it stimulates the stress response (the fight or flight response), activating the HPA's axis leading to the sympathetic nervous system being activated and the immune system, readying itself for attack to prepare for danger. This response is designed for actual dangerous situations and not for abstract situations which may signal danger, as the body is inherently designed to remain in a relaxed state.

Owing to the complexity of modern life evolving at such a rapid place, the physiological responses of the human body have not kept pace, which results in daily stresses such as loneliness, work stress, anxiety, or depression, with the forebrain consequently reacting similarly to these abstract stressors as it would to actual stressors. While the mind may know it is not real, the reptile brain cannot distinguish between the real or imagined, thus resulting in an alarmed stress response (Dienstbier, 1989; Frankenhaeuser, 1991; Taylor, 1999).

This alarmed stress response results in the hypothalamus being activated and releasing corticotrophin (CRF) into the nervous system, which in turn stimulates the pituitary gland which secretes prolactin, growth hormones and adrenocorticotrophic (ACTH) hormone. The release of ACTH stimulates the adrenal gland to release cortisol which is responsible for maintaining the body in homeostasis during threats. Rankin, L (2013)

While ACTH is being released by the hypothalamus, it also triggers the sympathetic nervous system (SNS) to engage the fight or flight response. The SNS triggers the adrenal gland to release epinephrine and norepinephrine which increase blood pressure and other physiological responses. The secretion of these hormones causes metabolic changes to occur throughout the body: blood vessels in the hands, feet, and gastrointestinal tract contract and vessels in the heart, large muscles and brain dilate to aid escape; pupils dilate and the metabolic rate increases, thus aiding reaction time; the respiratory rate increases and muscles tense to help expedite the flight response and the cortisol suppresses the immune function in order to reduce inflammation. When consistently triggered, these responses result in harmful damage to the organs of the body as such constant fear, depression, or work stress can have massive repercussions on the body, the negative physiological effect of emotions.

Benson (2008) studied the inverse of the 'stress response', the 'relaxation' response. This occurs when the conscious forebrain thinks positive thoughts and feelings such as love, intimacy, or hope trigger the hypothalamus to stop the stress response. In these occurrences, the SNS shuts down, in turn decreasing cortisol and causing adrenaline levels to decrease. This leads to the parasympathetic nervous system (PSNS) to taking over the immune system, which results in an increased ability to prevent disease. This illustrates the positive physiological effect of emotions upon the body.

The relaxation response particularly correlates with positive psychology and the Eastern philosophy (prana and chakra) idea that love is the healing factor for human beings, which was also demonstrated in the grand study conducted by Vaillant G E (2012), and those of Pert C B et.al. (1999), Lipton B H (2008). Alternatively, the consistent feelings and emotions associated with loneliness, anger, and resentment offer the opposite effect, leading to a harmful body and mind. This places an important need to take into account the emotions of clients in assessing their wellbeing, especially in terms of anxiety and depression.

2.5.3. The physiology of loneliness.

In the Grand study (Valliant G E, 2012), it was found that loneliness as an emotion and state of being had an important effect on health and wellbeing outcomes of participants. Loneliness can be described as the feeling of social isolation; it reflects the absence or neglect of personal relationships, an interconnection between the emotional and physical world. That being said, not all personal isolation is necessarily negative, for example, retreats, meditation, or personal time. However, chronic social isolation can be considered to be detrimental.

The harmful effects of loneliness have been mentioned in studies carried out by Sermat (1980) who found that between ten to thirty percent of people suffer from pervasive feelings of loneliness, whilst Hortulanus, Machielse, and Meeuwesen (2004) found that thirty-seven percent of people identified as feeling lonely described their health as either being poor or very poor. These findings illustrate that there is a link between feelings of loneliness and poor health. This finding has been further elaborated by a number of other studies that have found links between loneliness and increased rates of heart disease, breast cancer, Alzheimers, and suicidal thoughts, even indicating mortality rates after coronary artery bypass surgery (Sorkin, Rook, & Lu, 2002; Event, 1994; Stravynski & Boyer, 2011; Herlitz, 1998).

Cacioppo et al. (2000) have elaborated on these studies extensively with regard to the physiological effects of loneliness on the body. They have found that loneliness may lead to insomnia which causes lower glucose tolerance, elevated cortisol levels, and an increase in stress responses of the individual. Furthermore, people who feel lonely have demonstrated higher salivary cortisol levels throughout the day and thus discharge more corticotrophin, which results in the activation of the HPA axis, and in turn, the stress response. Thus, people who consistently feel lonely, as illustrated earlier, have a suppressed immune system rendering them unable to fight infection, and consequently experience poorer health.

According to Capcioppo (2000), feelings of loneliness have less to do with not spending time with people, but more about people altering their attitude when they are with others. He deems this to be so because lonely people tend to perceive others as potentially dangerous. This draws explicit links between negative feelings and beliefs with consciousness.

In turn, the mind differentiates loneliness as being disconnected, not belonging, and feeling unloved, while the reptile brain registers these notions as a danger, thus leading to the physiological stress response. This demonstrates that the interconnection between the mind and body is far wider than previously assumed and the need to include emotions and feelings in understanding wellbeing. Relationships which causes stress can also serve the same physiological response noted in loneliness (Steptoe et al., 2012). In this sense, emotional suffering starts in the mind, but later becomes an embodied experience (Steptoe et al., 2012). It pinpoints emotion not only as an experience of the mind, but also an experience of the body, and in turn stresses the need to look at the centre of where emotion originates in the brain, the amygdala.

2.5.4. Emotion in the brain: Amygdala and anxiety/ depression/ happiness.

The amygdala located in the limbic system is responsible for the processing and storing of various emotions. The amygdala experiences emotions even before the conscious brain does (Aggleton, 2000). The repetitive triggering of the stress response causes the amygdala to be more reactive towards apparent threats, resulting in a vicious cycle (Aggleton, 2000). The amygdala serves to help form implicit memories which trace past experiences that lie beneath conscious recognition (Rankin, 2013; Aggleton, 2000).

As a result, in terms of anxiety, the amygdala becomes more sensitised and the implicit memories become loaded with more heightened residues of fear, which results in the brain causing a constant feeling of anxiety that has nothing to do with present circumstances. At the same time, the hippocampus (which develops explicit memories) clears conscious records of occurrences, which becomes depleted by the constant recurrence of the stress response. This is due to cortisol and glucocorticoids weakening the synapses in the brain and inhibiting the formation of new synapses. Thus, the weakened hippocampus has difficulty in producing new memories, which results in fearful experiences being maintained in implicit memories, while explicit ones record conscious reasons for fear to be cleared (Rankin, 2013).

Depression, on the other hand, results from repetitive stress responses. This occurs due to cortisol leading to the release of norepinephrine (which creates the feeling of being energised and alert), dopamine and serotonin (hormone of pleasurable feelings) being depleted. This creates the feeling of apathy and the perception of distraction. The stress response itself reduces the release of serotonin (which facilitates a positive mood), causing the decrease of norepinephrine levels to become even further depleted, thereby continuing the feeling of a depressed mood.

Negative emotions also enhance the production of pro-inflammatory cytokines, increasing inflammation, certain cancers, arthritis, osteoporosis, and cardiovascular diseases. The increased experience of negative emotions results in the delay of healing (Glaser, Kiecolt-Glaser, 2005; Kiecolt-Glaser, Loving, 2005; Bartrop, 1977). These negative emotions or moods include: pessimism, helplessness,

hopelessness, anxiety, and depression, all of which have been found to increase a person's susceptibility to infections; cancer, heart disease, and endocrine disorders (Licinio, Gold, & Wong, 1996; Howell, Kern, & Lyubumirsky, 2007).

In turn, it has been found that happy people have stronger immune systems and develop over fifty percent more antibodies in response to influenza vaccines (Costanzo, Lutgendorf, 2004; Kohut, Martin, Senchina, Lee-Bain, 2005). This finding indicates a correlation between positive feelings and increased wellness, which has been documented in studies looking at the differences in immune functioning of HIV positive women (Ogg S, Melton, M Stine R, Byrnes C 1998).

Happiness has been studied less extensively than unhappy emotive states. In this regard, happiness and its effects are less understood. However, functional MRI scans and electroencephalography studies have found that happiness is located in the left prefrontal cortex of the brain which is activated by the release of the neurotransmitters such as dopamine, oxytocin, endorphin, nitric oxide, and serotonin.

These feelings of happiness are associated with two types of pleasurable feelings: the anticipation of something positive and the sensory pleasure of actually experiencing it. When either of these occur, the brain lights up in the nucleus accumbency (the pleasure centre of the brain) resulting in the release of dopamine and oxytocin. The release of dopamine increases the transfer of positive emotions between the left prefrontal cortex and emotional centres of the nucleus accumbency, resulting in a better mood. While the release of oxytocin reduces inflammation decreasing the number of cytokines directly inhibiting the release of ACTH, subsequently decreasing the responsiveness of the stress response. Thus, happy people have lower cortisol levels and feel less stress, fear, and other negative emotions and in general possess a better immune system leading to some researchers to view happiness as a form of preventative medicine (Rasmussen, Scheier, 2009).

However, results have been mixed regarding the effectiveness of happiness in treating disease (Veenhoven, 1991). This has been explained in two ways. Firstly, organs damaged by chronic stress response may be difficult to heal. Secondly, as disease mechanisms vary, the repair systems also vary. Thus, it can be demonstrated that there are inextricable ties between the type of emotions people feel and their wellbeing. This stipulates the need to include emotion, feeling, and belief in any attempt to formulate wellbeing. The above sections illustrate the links between the theoretical discussion of wellbeing discussed in this dissertation with other evidence-based studies. Both the theory discussions and these new studies reveal that when designing protocols to assess wellbeing of the client, it is a prerequisite to take into account the relation between the thoughts, feelings, beliefs, emotions, consciousness, and physical aspects of a client's current being; in other words, the inherent virtues of the client.

2.5.5. Learnings from molecular biology, epigenetics and quantum physics.

2.5.5.1. The intelligent cell: Learning from molecular biology.

Using understandings from quantum physics, Lipton (2005) illustrated that it is not just the brain that is the core of illness and emotions, it is rather the body in its entirety that affects every single system. He has demonstrated that the body is filled with thousands of brain elements carried in each and every cell (Lipton, 2005). Not only are these cells innately responsive, they are also not under the control of the central brain.

Previous models of cells located their functioning as being dependent on internal mechanisms (hormone secretion, autonomic nervous system, etc.), but recent research has illustrated that they are in fact dependent on external factors such as psychological stresses, nutrition, stress, and so forth (Lipton, 2005, xxvii).

2.5.5.2. Nature and the cell.

Genes in the Western model were thought to indicate one's predisposition to certain illnesses. Alternative approaches, specifically in the field of epigenists, are discovering that cells can change their nature without changing their genetic code. This field illustrates the more complex nature of disease and is challenging the prevailing medical opinions about illnesses such as cancer. Any illness can now be thought of in terms of other external stressors, not only in terms of one's internal and inherent predispositions (Lipton, 2005; The Burton Goldberg Group, 1994). Taking this into account, each individual is unique and requires a slight variation of nutrients or the relief of certain stressors to initiate the healing process.

Furthermore, the accepted location of the cell's 'brain' or governing nexus has been challenged. Initially it was understood that the nucleus contained the DNA of the cell and subsequently it has been theorised that it contains the cell's brain. Recent research has altered this view. The brain of the cell is located in its membrane, its skin. The flow of information (chemicals, hormones, etc.) flow through the cell's membrane and mobilises the cell. The DNA or nucleus (internal factors), once again, is not what determines the cell's action, but rather it is external cues located outside the cell that plays a role in the function of the body (Gerber, 1996; 2000; 2001; Pert, 1997, 2006; Oshman, 2000; Lipton, 2005; Lipton & Bhaerman, 2010).

Thus, once again, this research suggests that the body itself is not separate from the external influences while it is completely dependent on the internal functioning. In fact, even body cells are dependent on a host of external cues in order for the body to function and to be in a state of wellbeing. Hence, if even the building blocks of one's body are dependent on more than the body itself, the researcher posits that illness (and conversely, wellbeing) are more complex than a simple bacterium or virus entering one's self-mediated system.

2.5.5.3. An energized well-being.

Models are not necessarily real, but serve as conceptual tools to enhance a functional understanding. Even the idea of energy is a concept. If those within the mass consciousness of medicine were able to remember that the Newtonian mechanistic approach is also only a model based on 200-year-old concepts, the transition to the Einsteinien quantum model would be taking place with much less resistance (Cousins, 1976).

Moving the focus away from the cell to the body's receptors, a similar pattern emerges. Pert (2006) has been influential in the discovery that receptors operate according to energy and vibrations within the body. To restate, in quantum physics, energy is the supporting force of how one's reality operates. Matter actually consists of frozen energy and there are no absolutes (as explained earlier in Chapter 4). On an atomic level, matter does not exist with certainty; it is merely a tendency to exist. The notion of the atom being the smallest particle in the universe has been challenged by the discovery that the atom is constructed of sub-atomic particles (Kumar, 2009). These particles reveal that an atom releases energy, such as x-rays and radioactivity (Cousins, 1976).

Physical atoms comprise energy vortices that are constantly spinning and vibrating, and each atom has its own signature; that is, assemblies of atoms radiate their own energy identity pattern. Thus, every material structure, even individuals, radiate their unique energy signature (Herbert, 1985; Lipton, 2005; Kumar, 2009).

"Atoms are made out of invisible energy, not tangible matter" (Lipton, 2005, 71). The fact that energy and matter are the same is what Einstein concluded in his theorem, $E=MC^2$. The universe is one indivisible, dynamic hole in which energy and matter are so deeply entangled that it is impossible to see them as separate elements. This relationship runs in parallel with the mind and body, where both operate as one rather than two separate systems, as in the Cartesian-Newtonian framework.

Returning to the body's receptors, when chemicals flow through and into receptor cells, the chemicals and the receptors combine to stop or block other substances/chemicals that have an effect on emotions or information flowing to the frontal cortex, for example, an individual perceiving the world to be in a static state, where he/she feels helpless (Pert, 1997, 2006). The chemicals produced by that person's frontal cortex will release neurotransmitters (Bjorklund & Dunnett, 2007) that can be either received or blocked by the receptors, thus either further positively influencing or hindering the capabilities and behaviour of that emotion (Gerber, 2001; Lipton & Bhaerman, 2010).

This connection between the flow of chemicals and transmitters being similar to how the mind and body works, and how quantum physics conceptualises the way energy and matter interact, has informed the treatment technique of Gerber's (2001) energy flow and vibrational medicine. He views the human being as a 'series of interacting, multi-dimensional, subtle-energy system(s)' (Gerber, 2001:18). All these energy systems need to be in balance; if they are not in balance it will cause pathological symptoms that can manifest on a number of planes (spiritual, psychological, bodily).

Gerber's (2001) treatment works on balancing an individual's energy levels, as do all forms of intervention within the sub-discipline of energy psychology (as discussed earlier). Becker's use of balancing energy fields (1990) has been shown to aid the body in its healing capabilities (as cited in The Burton Goldberg Group, 1994). This is an example of another casualty of the denial of such therapies by the training programmes in Western medical schools.

Contextualising all of these elements into a unified whole, if one looks at energy medicine (often called vibrational medicine) and all other 'alternative' medicines, it is evident that they all operate on the principle of energy and its flows. Chiporak, acupuncture, cell therapy, TFT, NLP, Chinese traditional medicine, yoga, meditation and hypnosis all posit that wellbeing works on the principles of energy and the way that it flows *through* the body, and *between* people.

These new understandings of how the mind and body are interrelated, calls for an understanding of wellbeing which can accommodate them. Previous models have echoed the need to foster the values of positive emotions to facilitate positive health outcomes, but they have failed to show how these emotions can be linked to such outcomes. The controversial research that has been discussed displays such a connection, and enhances it by positing that it has more to do with a deeper understanding of what consciousness means. In this light, the author draws upon virtues and the interrelated components of beliefs, emotions, and behaviour in developing his philosophy of wellbeing.

2.6. The Philosophy of Monistic Idealism: Placing Belief in Well-Being

As mentioned earlier, we live in a world with a very strong philosophy based on material realism. Amit Goswami, in his book *the self-aware universe* (1995), describes monistic idealism as the "antithesis of material realism". According to him, consciousness and not matter is fundamental. It is consciousness that determines the world of matter and the world of mental phenomena, that is, thought. Therefore, consciousness is the only ultimate reality. It is within our "intellects, souls and bodies, in heaven, on earth and whilst remaining the same in itself. It is at once in, around and above the world, super-essential, a sun, a star, fine water, spirit, dew, cloud, stone, rock, all that is" (Goswami, 1995).

Of all the above descriptions, consciousness which comes to us through complementary manifestations as mental experiences such as thought, is not material in nature. Idealists, who consider consciousness as the primary reality, do not propose that consciousness is the mind, which causes possible semantic confusion (consciousness versus mind). According to monistic idealism, the consciousness of the subject is the same as the consciousness that is the foundation of all being, as it is intuitive.

This dissertation argues against the commonly held assumption that spirituality and religion are synonymous; instead it argues that spirituality is antonymous to materialism. The principles of tangled hierarchy, nonlocality, downward causation, and discontinuity within quantum physics pinpoint spirituality as a field of energy of

which every individual is a part. This aligns with Einstein's idea that: Everyone who is seriously involved in the pursuit of science has become convinced that a spirit is manifest in the law of the universe – a spirit vastly superior to that of man (Ó'Toole, 2012).

In this manner, the concept of spirituality herein has less to do with its discovery in religion, but rather what science has discovered about spirituality. In metaphysical inquiries into spirituality it has become apparent that an individual's thoughts construct their reality, as illustrated in the principles of downward causation and nonlocality (Oliver Passon, 2006). It appears that within the field of wellbeing, should it take these principles into account, that the power of belief is paramount in the understanding of wellbeing. The precursor towards appropriating this power is the 'virtues' that a person has acquired, which affects their beliefs or those feelings which resonate with their spirituality.

Neuroscientists have indicated that an overwhelming percentage of people's thoughts are controlled by their preprogramed subsconscious mind (Andreas & Andreas, 1989). The pre-programming of the subsconscious can be related to the beliefs that individuals acquire or learn as they mature, which illustrates people view the world through a 'movie of the past' rather than 'thinking' through everyday matters in that their beliefs that they have acquired during their past affects how they understand the present. An integrative philosophy of wellbeing that takes account of the preprogramming of the subconscious role in behaviour should strive to instil the ideal of a universal truth among clients and clinicians. A universal truth that thoughts have power and that a field of infinite possibilities waits for both parties with regards to facilitating wellbeing.

Quantum physics defines this field as an 'invisible mobbing force that influences the physical realm'. According to Bohr, we need to develop a conscious relationship with energy ('as even matter is nothing but frozen light' (Polich J.B p.217), since during the last hundred years physicists have discovered that energy is interwoven in the very fabric of an individual's reality. Thoughts become energy waves that subsequently affect everything else in the universe. Grout (2013) isolated nine energy principles stating that there is firstly an invisible energy force or field of infinite possibilities. This field is impacted by the judgements that an individual makes, so that the reality is in itself a wave of possibilities that has been 'observed' into form. Therefore, individuals impact the field and draw from it according to their beliefs and expectations.

Following this line of thought, the connection between the individual as a field of energy and the individual's thoughts as energy waves expands into their own reality. It suggests that thoughts and consciousness impact matter, which in turn provides the scaffolding of the physical body. Utilising the principle of non-locality, the individual as a field of energy is thus in tune with all other individuals in the universe, which is limitless, abundant, and strangely accommodating (Grout, 2013, pp. xxiv-xxvii).

These principles based on quantum physics demonstrate that the invisible energy realm is the primary governing force of the material realm. It is the blueprint that

forms reality and can thus be seen as one of the universal truths. In terms of this truth, the universe is a construction of waves and particles of energy that conform to people's expectations, judgements and beliefs, which albeit subtle have extremely transformative effects, as they play important roles in the life-experiences of people through their thoughts, emotions, and consciousness. Positing thoughts as energy waves thus stipulates that thoughts constitute vibrational energy waves that interact and influence the force field of the universe itself (Grout, 2013, p.4).

The universal truth of virtues being at the core of wellbeing then places an individual's free will above that of his or hers pre-determined environment. In fact, seeing virtues and the beliefs which occur alongside them at the core of wellbeing, stipulates that it is the individual's free will that facilitates the environment in which they surround themselves as their beliefs, thoughts, and emotions resonate and interact with the universe, thus creating that individual's reality or environment in which they find themselves. By wellbeing taking a hold of such a powerful concept, the field of wellbeing transforms as the individual or patient or sufferer is no longer defined by the diseases or illness they have but rather the 'dis-ease' that they feel. It also stipulates that in order to overcome this 'dis-ease' means that health practitioners should place the client at the forefront and not the illness or the client's somatic problems but what the client feels works best for them.

In this light, Myers and Sweeney (2008) argue that for each person there is a set of self-directed life tasks in which they must be involved: sense of worth, sense of control, realistic beliefs, emotional awareness, coping, problem solving, a sense of humour, nutrition, exercise, self-care, stress management, gender identity, and cultural identity[2]. These tasks are not new as they have been described in writings from Eastern Philosophy to contemporary research in numerous disciplines.

The author of this dissertation sees these self-directed tasks drawing parallels with the "Five Selves": the creative self, the coping self, the social self, the essential self, and the physical self. These five aspects of the individual, which contain the self-directed life tasks of the individual are reminiscent of the five classical perspectives of psychology (Atkinson et al., 1990).

The creative self with its self-directed tasks that encourage an individual to form a sense of humour, problem solving, and stress management, could be seen to be aligned with the cognitivist perspective. This approach, in its emphasis of the neuroplasticity of the brain and its central focus on the role of cognition in behaviour, could be seen to relate to the creativity or problem solving skills that an individual possesses and must facilitate during their life experiences.

While creativity may be aligned with the cognitivist approach, the coping self and its tasks of stress management, emotional awareness and coping, self-care, and identity are strongly orientated to the phenomenological perspective. This orientation

is evident in the phenomenological perspectives which focus on the individual's perceptions of events and their understanding of reality.

The essential self could be seen to be in parallel with the psychoanalytic perspective. The life tasks of the essential self, sense of worth, sense of control, gender identity, and cultural identity, can be related to the fundamental theories of psychoanalytic perspectives, being consciousness and early experiences.

The self-directed life task of self-care, nutrition, reminds one of the aspects of the biological approach in that these tasks of the physical self-prioritise the body. The biological approach views wellbeing through the psycho-somatic perspective wherein the body or the brain are seen to play critical roles in 'dis-ease'.

In contrast, the social self and its life tasks could possibly reflect the behavioural perspective. This perspective highlights the importance of an individual's environment upon their behaviour and thus stresses the need to understand the person and the social environment in regard to understanding that person's self.

Thus, through the years, each aspect of the self has been and continues to be studied through certain isolated perspectives. While the self-directed life tasks and selves are not mutually exclusive in each of these categories, for each of these psychological perspectives, the understandings of the other perspectives have been viewed as being semantically different, while not fully capturing the complexity of the individual. The author instead argues that while the semantic differences may remain between these perspectives, each has studied an aspect of the individual and has thus contributed to a piece of the puzzle of the human self and wellbeing. The problem within wellbeing is that it draws from individual puzzle pieces (a certain aspect or perspective) in understanding a client's dis-ease, thus not fully realising that the dis-ease could be related to more than one puzzle piece. Also, when consulting two or more perspectives that are often regarded as conflicting and not complementary, the client remains in their distressing situation.

This author of this dissertation argues that by combining these puzzle pieces to form a full picture of the individual in diagnosis and treatment, by integrating each part into the whole leads to a more coherent understanding of the individual for the practitioner and client. This in turn centralises the client in wellbeing and not the affliction and has more in common with the universal truth of virtues as outlined above.

To take this a step further, new terms have been introduced such as "salutogenic orientation" or "health causing" that centralises what is right with the client instead of what is wrong. This is followed by the fortigenesis or the origin of strengths, which according to Stumpfer, relies on the individual's beliefs of coherence, locus of control, self-efficacy, hardiness, potency, and learned resourcefulness, which also bear strong similarity to emphasis of positive psychology being placed on inner strengths, that is, the human capacity to self-actualise. These beliefs or understandings of the individual correlate with the five selves and the five psychological perspectives outlined above. While they are semantically different from

each other, they are all attributed to the same individual, but in terms of different aspects of him or her.

The term “fortigenesis” has been followed by psychofortology (Wising & Eeden) which is viewed as the psychology of strengths that looks at wellness comprising physical, spiritual, psychological, social, emotional, and intellectual wellness, reminding one of Goswami’s (2011) five bodies. Each of these aspects of wellness can also be considered to correlate with the five selves and classical perspectives of psychology; however, this view takes a step further by viewing them from a single integrated perspective. Consequently, this has resulted in noteworthy research that illustrates links between an individual’s behaviour and their genes; thought and emotion in mental health, and how creativity and communication play a central role in wellbeing, to name a few examples.

2.7. Conclusion

The theme of this chapter is that there is ‘nothing new under the sun’ and this can say to be true throughout this dissertation. The author has suggested links between meta and quantum physics, Eastern philosophy, contemporary research, the understanding of self and the classical psychological perspectives. However, it can be said that this is not the first time an individual has attempted to integrate understandings of wellbeing as many self-help books and much research have shed a similar light. Books such as *the power of thought (Hamblin HT 2008),* or *Care for the Soul, Moore T (1992* delves into how people should appreciate their depth in relation to their own wellbeing, have all touched a similar notion. The length of time that these theories and understandings have been ignored concerns the author. It is this notion that the author wishes to transform, as the dogma on separateness between all things, as illustrated in this chapter, is contrary to the understandings of the universe that have existed for millennia (and are resurfacing) that argue against delineation but rather incorporation.

Examining psychology and all of its schools of thought, one can witness a similar pattern emerge. The behaviourist, cognitive, psychoanalytic, and phenomenology perspectives (as discussed earlier in this chapter) all place an emphasis on altering or challenging how the individual visualises their reality and experiences the world. The manner in which the individual describes their energy's interaction with the environment informs the ability to function and operate as a healthy individual within society.

It is with these understandings gained from psychology, wellness, and quantum physics that the notion of virtues in understanding wellbeing and aiding the development of a wellbeing philosophy finds ground. The understanding of a person being capable and able to challenge their role in their own wellbeing is powerful. It places the individual at the centre of wellbeing and the centre of their change. It does not see wellbeing as static, but rather as a dynamic, changeable concept that moves from one context to another and is enmeshed within a person’s perceptions, feelings, and actions (all of which can be challenges or changed by themselves).

Furthermore, a virtues-perspective within a screening philosophy places the counsellor as a mediator towards developing a person's competencies in wellbeing rather than being the sole guide. It is a philosophy that incorporates these ideals as outlined in the next chapter.

Chapter 3: Literature Review
An Integrated Well-Being Philosophy for the Counselling Profession

The secret of the care of the patient is in caring for the patient (Francis Peabody) It's supposed to be a professional secret, but I'll tell you anyway. We doctors do nothing. We only help and encourage the doctor within (Albert Schweitzer)

3.1. Introduction

Schweitzer's view on care resonates with the theoretical review that has been discussed in the previous chapters. It has been illustrated that the interaction of the body and mind are far more complex and intrinsically linked to wellbeing. This shifts the power of new understandings in wellbeing towards the power of the patient while it is the clinician who facilitates wellbeing, it is the patient who instils it.

Peabody's understanding of caring for the patient is the central theme within this chapter. The philosophy discussed below attempts to shift the notion of care from 'of'' the patient to 'for' the patient in describing clinical procedures that incorporate understandings from quantum physics, classical psychology, contemporary psychology, and relevant wellbeing theories that emphasise leading and pacing the patient in a direction towards fulfilling their own wellbeing. Central to these procedures, as substantiated by empirical studies, is that emotions and beliefs exert a direct impact on the physical body.

This chapter uses the clinical procedures outlined as a move towards illustrating an integrated philosophy of wellbeing that takes account of the myriad perspectives covered in previous sections. As such, this chapter is a discussion of the philosophy itself and how it should be utilised in a clinical setting.

In order to contextualise these procedures, the author firstly summarises the argument of the interrelationship between consciousness, body systems, feelings, and virtues that can be used to bridge the gap between medicine and mind. Following this, a Quick Screening and Diagnostic Assessment (QSDA) procedure and the rationale underlying its use in facilitating prompt assessment of depression and anxiety in clientele are detailed. The author subsequently describes the Checklist: Severity of Mental Problem (CSMP) which offers a protocol to quickly and accurately establish the need for referrals to healthcare specialists. At this point, the pacing and leading of the client towards wellbeing is outlined in the use of the Wellbeing Questionnaire (WQ) and the Core States (CS) reference that embody the holistic sense of wellbeing that was earlier outlined theoretically. These protocols, when used together, are understood to constitute an integrated philosophy of wellbeing.

At the core of this philosophy is the holism of the client and their diagnosis, allowing rapid diagnosis and referral for the clinician so as to allow the quickest access to facilitating their wellbeing in terms of their direction and location on the wellbeing

continuum. This not only allows the ability for clinicians to seek out the best method of treatment for the client, but also facilitates the power for the client to change within him or herself.

3.2. Mind-Body Medicine: Body Systems-Thoughts-Beliefs-Emotions

As discussed in earlier chapters, the lifestyle choices of people place them on the continuum between dis-ease and well-being. Furthermore, from a non-materialistic viewpoint, physiological changes correspond with a person's wider environment and their interaction with it in regards to their life, creative expression, and freedom; spiritual connectedness; financial situation; sex life; and lifestyle; as well as mental and emotion stability. These aspects of wellbeing affect a person's interaction with their environment in that they cause either a stress response or a relaxation response.

These responses correspond with the principles of wellbeing described in positive and transcendental psychology as well as the theories of wellbeing of Strumpfer (1995), Coetzee and Cilliers (2003), and Adams, Bezner, and Steinhardt (1997). For example, positive emotions such as joy and initiate the relaxation response, while negative emotions such as judgement and fear trigger the stress response. Both negative and positive emotions then cause physiological reactions. This stresses that to focus solely on the body without taking account of consciousness is futile, as much of this dissertation has illustrated.

The human body is a mirror of the interpersonal, spiritual, sexual, professional, creative, financial, environmental, mental, and emotional aspects of the person, which the first part of the questionnaires (QSDA and CSMP) outlined in this philosophy take into account. The first part of the screening strategies effectively test for the emotional state of the individual in a variety of questions aimed at discerning the placement of the individual on the continuum of dis-ease and well-being. When designing protocols, both the theory discussed and the aforementioned new studies demonstrate the need to assess the clientele's wellbeing while taking into account the relationship between the thought-feeling-belief-emotion-consciousness-physical aspects of a client's current being is a prerequisite. The author now turns to the first of the questionnaires designed to assess the wellbeing of the clients utilising the QSDA. He outlines its design, measurement, purpose, and application while also furnishing examples of its use.

3.3. The Quick Screening and Diagnostic Assessment (QSDA)

This dissertation is based on data collected which illustrates that counsellors in **South Africa suffer with incorrect and inadequate diagnoses of their clientele's dis-ease**. This is further compounded by evidence that firstly counsellors (in their own beliefs) struggle to refer clients to specialist healthcare professionals, and secondly, that referrals are often poorly constructed and are at times at the extreme point of the client's distress (derived from questionnaires completed by counsellors).

The QSDA is an assessment measure that advocates quick screening which can lead counsellors and clinicians towards a fuller conceptualisation of the client's problem while at the same time facilitating quick and complete referrals to other healthcare specialists.

The QSDA should be used when a client presents a problem by stating that they are not at ease with their current situation. This could extend to such proclamations (but not restricted to), "I do not feel well"; "I have a problem"; "I feel I am going crazy". Following such statements, the counsellor should immediately refer to the QSDA. This is based on the principle that in critical situations, where clients are showing extreme distress (such as a heart attack or severe suicidal ideation), the counsellor/ practitioner should use allopathically informed procedures to allow immediate relief. Once this relief has been sustained, the counsellor/ practitioner can move towards more ayuverdic treatments.

3.3.1. Design.

The QSDA was compiled by selecting the diagnostic significant symptoms of major depression and certain anxiety disorders as described by the DSM-IV-R. These symptoms have been categorised according to the five personal areas of functioning and have taken into account the theoretical underpinnings discussed above and elaborated in chapters 2, 3, and 4 in the formation of questions used to assess the client's wellbeing[3].

The first area is that of the 'Affective' category, which encompasses the individual's feelings or emotions. The 'Cognitive' category, specifically assesses the client's thought content (such as cursing God) and their thinking abilities (their ability to concentrate). The client is further assessed in terms of the ability to show interest and motivation, that is, their goal orientated behaviour which is categorised as their 'Motivational' aspect. The client's 'Behaviour' is also assessed in terms of the actions they demonstrate, for example, outbursts of anger, while the 'Somatic' category takes account of the physical sensations and experiences such as nausea, sweating, or trembling.

These five categories have links to four of the five Gross and Subtle bodies outlined by Goswami (2011). In the 'Affective' category, the client's feelings are assessed, which runs in parallel to the 'Vital' body which is also concerned with what people 'feel'. Similarly, the Cognitive and Behaviour categories both have links with the 'Mental' and 'Physical' body in which each of these stresses the relationship of thoughts and behaviours respectively. The Supramental body, however, in its emphasis on virtues and motivations, can be linked to the intuitive aspects of virtues and motivations in determining the behaviour and beliefs of people. In this way, the

‘supramental body’ has some parallels with the ‘motivational’ component of the QSDA.

The information required to assess these categories is obtained by asking specific questions related to each area of functioning. These questions have been formulated to be open ended so as not to restrict the client’s personal distress. In most cases, two questions have been provided. The second question is intended to explain the first one. Only when a client cannot provide a satisfactory answer to either of those two questions, should specific symptom related questions be asked. The latter is expected to be hardly ever necessary.

3.3.2. Measurement.

The QSDA is intended to measure the presence of major depression, dysthymic disorder, general anxiety disorder, phobic disorder, panic disorder, obsessive compulsive disorder, and post-traumatic stress disorder (PTSD). The DSM-IV-R notes that more than fifty percent of the population experience either anxiety or depression, or both at the same time at some point in their life. It stresses the need for measurements such as the QSDA to help in providing quick and effective assessment.

These psychological disorders are some of the most prevalent reported cases of mental dis-ease that exert an impact on a client’s entire wellbeing. As such, they are understood holistically in terms of the categories referred to above.

3.3.3. Purpose.

The main purpose of the QSDA is to provide a means to conduct a quick (ten to fifteen minute) and fairly accurate estimate of a client’s degree of depression and anxiety. Its intention is not to provide a client with an accurate diagnosis of their mental status. This could only be achieved by an intensive interview in a face to face consultation. However, with the help of the QSDA, it could be possible to fairly accurate **estimate a client’s degree of depression and anxiety**.

3.3.4. Application.

The counsellor will use a computer program during the assessment. As symptoms are mentioned by the client during the assessment, the counsellor will select the applicable symptoms in the computer program. As the assessment progresses, the program illustrates the various diagnostic indicators by means of a bar graph and at the end of the assessment, a fairly accurate estimate of a client’s degree of depression and anxiety is achieved.

The diagnostic indicators are related to the measurements outlined above: Depression, Generalized Anxiety Disorder (GAD), Obsessive Compulsive Disorder (OCD), Phobic Disorder, Panic Disorder, and Post Traumatic Stress Disorder (PTSD).

For the purpose of the is research, the exact computer program algorithms do not fall into the scope of the study and therefore they are not included.

3.3.5. Procedure.

The following section outlines the procedure of the QSDA by detailing the interaction between the counsellor and client.

3.3.5.1. Step one.

The counsellor asks the client's permission to take him or her through the QSDA. The clinician follows this by outlining the approximate time that the screening takes and the purposes of the QSDA. Subsequently, the counsellor poses possible questions and gives details of the types of responses that they would prefer from the client. The client is allowed to take notes to help clarify any misunderstandings. An example of a possible introduction to the QSDA is found below:

> *May I take you through our quick screening for depression and anxiety questionnaire? It will take approximately 15 minutes to apply and will provide you with a fairly accurate estimate of whether or not you are suffering from depression or anxiety. If so, this could help you obtain more clarity on what exactly is happening to you. Suffering from depression or anxiety can be a scary and confusing experience. It will entail answering a few questions regarding your feelings, thoughts and behaviours. You don't have to provide me with any personal details about the real nature of your dilemmas or problems now. The questions are aimed at identifying the symptoms of depression and anxiety. I might ask you for instance 'Do you have anything at present in your life with which you have difficulty coping?' Your answer will be either yes or no. If you want to provide me with specific information, that's fine as well. I will ask you several questions to determine which procedure would be the most useful to you. It will help to have paper and a pencil at hand thus enabling you to make some notes while I give you certain information.*

3.3.5.2. Step two.

After the client has been made aware of the purpose of and time required for the QSDA, the counsellor poses all the questions regarding all the areas of personal functioning such as 'affective', 'behavioural', 'cognitive', 'motivational' and 'somatic' aspects, which take into account the integrative nature of wellbeing as discussed in the theoretical framework (refer to Appendix for complete QSDA).

To engage the client's affective functioning, a question such as, "How do you feel most of the time?" can be posed by the counsellor who then provides options of feelings for the client to choose from. The client may respond that they feel 'depressed', 'have a loss of pleasure', or they may be feeling on edge.

The counsellor will follow by assessing the client's cognitive operation by posing the question of what bothers the client about their thoughts or thinking abilities. This may be followed by the clinician asking if the client has thoughts which scare or shock them. The client may refer to a lack of concentration or excessive worrying, and may stipulate that they have or do not have thoughts which shock or scare them.

The client's motivational aspect may be assessed next in a question such as, "How motivated or interested are you in things you used to do or enjoy and your work", following with the question, *"Are you purposefully avoiding certain situations"*. Clients may respond that they are experiencing a lack of interest or that they may have none. Once all the motivational aspects of the client have been assessed, the client's behaviour is scrutinised.

An open question regarding which behaviours the client conducts that perturb them may be posed to gain insight into their behavioural functioning. The client's response is followed by a question about which specific behaviours interfere with their everyday functioning. This question was constructed in order to fully assess any behavioural interference with the individual and their lifestyle.

Lastly, their somatic feelings are questioned by questions such as, "*What happens to your body when you feel tense or panicky?*" The client may respond by mentioning restlessness, loss of appetite, or trembling.

3.3.5.3. Step three.

As the client is listing their symptoms or describing their experience to the counsellor, the counsellor selects the corresponding symptoms on the computer program.

3.3.5.4. Step four.

The client is then asked about the frequency or duration of the symptoms so as to assess their length or frequency of distress. The client can respond with time such as two or more weeks, days, or months so that the counsellor may have a complete picture of the length of time the client has been feeling affected.

3.3.5.5. Step five.

Once the questions have been asked, a colour-coded bar graph displays the level of each diagnostic disorder, with the blue bar signifying depressive symptoms, a red bar displays the levels of GAD, OCD is shown in a grey bar and the green bar illustrates the level of Phobic Disorder, whilst the yellow and pink bars show levels of Panic Disorder and PTSD, respectively.

3.3.6. Procedure.

The table 3.1 illustrates two different clients and their responses through a fictionalised use of the QSDA.

Table 3.1

Use of the QSDA

QSDA Category	***Example Questions***	**Client A Response**	**Client B Response**
AFFECTIVE	*How do you feel most of the time?*	I don't feel anything	I feel on edge
	Which of the following describes your feelings the best?	Depressed mood Loss of pleasure Guilt feeling	
COGNITIVE	*What bothers you about your thoughts or thinking abilities?*	Lack of concentration	Excessive worrying
	Do you have thoughts which scare or shock you?	Suicidal thoughts	Indecisiveness
MOTIVATIONAL	*How motivated or interested are*	Lack of interest/ motivation	None

	you in things you used to do or enjoy e.g. hobbies, chores, and your work?		
	Are you purposefully avoiding certain situations?		
BEHAVIOUR	*Which behaviour do you display that bothers you?*	Loss of energy	Hyper alert
	Which of your behaviours interferes with your everyday functioning?	Social withdrawal Crying more than usual	Social withdrawal
	What happens to your body when you feel tense or panicky?	Restlessness Loss of appetite	Muscular tension Trembling or shaking
FREQUENCY / DURATION	How often do you experience this and in which intervals?	Two or more weeks (within three months)	One or two months (within one and a half months)
DIAGNOSIS		Depression	Vague signs of anxiety

3.4. Checklist: Severity of Mental Problems (CSMP)

While the QSDA identifies the type of disorder that the client is encountering within life, the Checklist Severity of Mental Problem (CSMP) assesses the degree of the severity of the mental problem (refer to Appendix B).

The diagnostic indicator of an adjustment disorder with depressed mood, anxious mood, or mixed emotional features can be obtained only during the administration of the CMSP. No provision is made for adjustment disorders for disturbances of conduct.

3.4.1. Design.

The CSMP is based on the assumption that in order to determine the degree of the severity of a client's mental problem, their clinician needs to take into account: (1) the number of psychiatric disorders; (2) matters related to suicide; (3) impairment in areas of the client's life; (4) substance abuse; (5) client's previous treatment measures; and (6) the social support the client has at this specific point in time. These criteria are drawn from the theoretical discussion and DSM-IV-R specified earlier, which stresses the need to understand that a client's wellbeing is embodied in all aspects of their life.

3.4.2. Measurement.

The CSMP measures the degree of severity of the client's mental disorder and suggests a method of intervention that should be adopted by the counsellor. Measurement is placed into three categories relating to the severity of presenting symptoms from the highest-level being suicide risk to high risk, followed by the lowest level, moderate to low risk.

Each category refers to a specific intervention method. Clients whose measurement is deemed to be of the highest risk are rated as suicide risk and it is suggested that the client is immediately referred to a mental health professional. Clients who are labelled high risk are referred to a mental health professional as soon as the client is able to do so, while those who present as moderate to low risk continue with the multi-disciplinary screening.

3.4.3. Purpose.

The above outlined factors resemble the axis V diagnosis as per DSM-IV-TR to a great extent. Nonetheless, the CSMP does differ from the DSM-IV – axis-V diagnosis in several ways.

This is firstly seen in that the CSMP does not access personality functioning. The reason for this is that such evaluation is very time consuming and is best conducted in a face to face situation and over a period of time. Secondly, the CSMP provides specific ratings as well as specific guidelines regarding rating. Lastly, certain sub factors of the CSMP have been preselected for quick "diagnosis" and are geared to identify the most serious cases as quickly as possible.

3.4.4. Application.

It takes approximately five to ten minutes to administer the CSMP. The relevant questions to be asked by the counsellor have been specified and are illustrated by sub-specific examples, each with their specific rating. The latter can also be utilised

as a guideline whenever a client experiences problem which differ from the specified ones. The ratings are as follows: *Zero*, *One*, *Two* and *Three*.

The computer calculates the score and provides an estimate of the degree of severity and suggestions regarding the indicated method of intervention.

3.4.5. Example of use.

To take the previous two clients who were presented in the QSDA example (see above), an example of these clients' follow-ups with the CSMP is presented in Table 6.2.

Table 3.2.
Follow up regarding the CSMP

		Client A	Client B
A	Number of psychiatric disorders	1	1
B	Suicide	3	0
	Impairment in areas of life	3	
	Interpersonal	2	1
C	Work	0	2
	Financial	0	0
	Health		0
D	Substance abuse	0	3
	Previous treatment		
	Hospitalization	3	0
E	Psychologist	1	0
	Psychiatrist	1	0
	Medication	1	1
F	Support system	0	0

Looking at areas C and F specifically, strong links with current wellbeing theories are foregrounded. In C, the impairment in areas of life shows links with the environmental factors affecting wellbeing (as discussed in Chapter 4), while in F, the support system draws on the ideas of the physiology of loneliness as discussed in section 5.2 and Chapter 4.

According to this protocol, client A scores high on factor B. Whenever factor B is prominent, it is necessary to refer the client to a clinical psychologist or psychiatrist. The scores for client B indicate that there are problems in A+ (C is 4 or less) +D +E, which places this client in the low risk group. This client could be helped by applying counselling procedures and continuation to wellbeing questionnaire, which is discussed below.

3.5. The Well-Being Questionnaire (WQ)

While the QSDA and CSMP are focused on the quick clinical assessment of the client, the Wellbeing Questionnaire (WQ) represents a more explicit undertaking into assessing the complete wellbeing of the clients as understood by the theoretical framework discussed throughout this dissertation.

The author firstly outlines it design, picking up key aspects to demonstrate how the wellbeing questionnaire was developed through the theoretical framework explored in this dissertation in conjunction with research obtained by the researcher during the course of his study. An explicit focus on how wellbeing is underpinned by virtues is discussed at length in this section followed by its relationship with the core states, and subsequently, body systems, which represent the core facet of wellbeing outlined in this dissertation.

3.5.1. Design.

The in-depth wellness questionnaire comprises multiple questions with a spectrum of five alternatives, namely never, rarely, sometimes, usually, and always. These questions are informed through an understanding of virtues and beliefs drawn from the researcher's theoretical frame relating to learnings drawn from quantum physics, psychological perspectives, and empirical models of wellbeing. Intrinsic to its design is the notion of virtues.

3.5.1.1. Virtues.

Virtues represent the underlying components of one's belief system, which in turn is representative of how one 'feels' about something – thus there is a link between emotions and virtues. Subsequently, emotions and virtues are linked to actions. As Schwartz and Boehnke (2004) state, virtues are beliefs that are inextricably tied to emotion; they are not objective, cold ideas.

In order to flourish, people need to develop virtues of independent thought and acknowledged social dependence. Indeed, they need to be explicated in practice as they greatly aid wellbeing (as discussed in chapters 2 and 4). Meilaender (1999) notes that a life comprising virtues 'offers hope of delivering us from the moral schizophrenia of our culture'. In this sense, virtues are not merely subjective choices that some individuals make; they are traits that are absolutely necessary for the achievement of wellbeing.

A virtue is a pattern of thought and behaviour; the word stems from the Greek for 'moral excellence' (Prior, 1991). One's collection of individual virtues constitutes one's value system, and these value systems differ from culture to culture. Everyone has a core of underlying values that contribute to one's belief system and form a core from which one operates and reacts. Interestingly, the archaic meaning of the *word* virtue in English from the 13th to the 19th century meant 'the inherent *power* of a

god, or other supernatural being' (Webster's Revised Unabridged Dictionary, 1913. Italics by author).

3.5.1.1.1. Nine Virtues of Well-Being Questionnaire.

Taking these understandings into consideration, The Wellness Questionnaire is formulated with nine characteristic virtues of: love, joy, peace, patience, kindness, goodness, trust, humility, and self-control.

The nine virtues relate to Meyers and Sweeney's (2008) self-directed life tasks in which each correlates with aspects of the individual's selves (see chapters 3 and 4). Love can be related to an individual's appreciation and respect of their ability to care for themselves (self-care) and their emotional awareness of others. It also takes into account an individual's love for themselves and their cultural and gender identity. It is fundamentally underscored by their understanding of their self being worthy of love and giving love to others.

Joy, on the other hand, revolves around an individual's sense of humour, nutrition and exercise. It is the ability of the individual to find happiness in their environment and others and as such also comprises the task of sense of worth. An individual must direct themselves and see themselves as having the ability to find joy and accept joy within their lives.

While love and joy are primarily related to the individual's sense of worth, peace, trust, patience, and self-control can be related to a person's control. The individual should orientate themselves to ways of controlling behaviour and setting realistic beliefs for themselves as without this they will always be found wanting.

Kindness, goodness, and humility can be viewed as pertaining to several life tasks, but focus more on an individual's outlook. These virtues have less to do with religious or cultural understandings, but more to do with the ways in which they conduct themselves in their environment.

3.5.1.1.2. Opposing categories of virtues.

According to the Oxford Dictionary, attitude is defined as "a settled way of thinking or feeling about someone or something, typically one that is reflected in a person's behaviour" (2012). Jung explains attitude as "readiness of the *psyche* to act or react in a certain way" (Jung, [1921] 1971: par. 687, Italics by author). Attitude is shaped by our manner of thinking, feeling, and acting. The author therefore concludes that an attitude determines our way of life and furthermore is based on beliefs, emotions, and actions (see chapters 2 and 4).

Beliefs, emotions, and behaviour as the three determinants of attitude can be explained as being a causal flow. As Eckhart Tolle explains in '*A New Earth'*, "thoughts that trigger emotional responses in the body may sometimes come so fast that before the mind has had time to voice them, the body has already responded with an emotion, and the emotion has turned into a reaction" (Tolle, 2006, p. XX).

A belief, as defined by Wolinsky S H (2000), is “a solidified thought which can become a value or evaluation of self or the world. It can be attitudinal if it determines a way of life or living” (pp. 80). The Oxford dictionary defines belief as “an acceptance that something exists or is true, especially one without proof” (Oxford Dictionary, 2012). Beliefs are constructed by subjective memories and the interpretation of past events and experiences. These interpretations become solidified thought which then creates an emotional value of the perceived self and the world. Therefore beliefs, as they form part of attitude, are based on everything that we have learned in the past in a subjective perception. As Doob states, “learning can account for most of the attitudes we hold” (1947).

Every form of healing, whether physical or psychological, that I know of gives credence to the fact that present behaviours are often created or shaped by past behaviours and past events. What’s important about past experiences is not the content of what happened, but the impression or belief that the person built from the experience (Diltz, Hallbom, & Smith, 1990).

In this manner, “we never experience the world directly – we “re-present” it to ourselves through internal images, sounds and voices, and kinesthetic feelings. (Diltz, Hallbom, & Smith, 1990). This is congruent with the views of Goswami (2011) that emotions originate and are constructed from beliefs (see Chapter 2). “Dysfunctional thinking is what the body reacts to with negative emotion” (Tolle, 2006) and the opposite can also hold true. Therefore, when correlated with the author’s model, functional thinking and transforming beliefs is what the body reacts to with positive emotions, as all day-to-day behaviours carried out are determined by emotional values and can be changed only by altering beliefs (Dilts, et.al. 1996).

Each virtue thus consists of its own relevant positive and negative attitudes. The positive and negative attitudes are then subcategorised into transforming beliefs versus unhealthy beliefs which create positive emotions versus negative emotions, and consequently, healthy actions versus detrimental ones.

Table 3.2.
Relevant positive and negative attitudes

Virtue	Love	
Attitude	**Positive Attitude**	**Negative Attitude**
	Transforming beliefs	Unhealthy beliefs
Beliefs	I am lovable. I am significant. I am whole	I am unlovable. I am insignificant. I am flawed
Emotions	Positive emotions	Negative emotions

Behaviour	Forgiveness, significance, compassion, and empathy Healthy behaviour Loving myself and others, and being committed to the truth	Unforgiveness, feeling of insignificance, and resentment Harmful behaviour Selfishness

3.5.1.2. Core states.

In the theories of wellbeing (described in chapters 2 and 4) and Goswami's (2011) notion of the 'bliss' body, as well as in humanistic and transcendental psychology (see Chapter 3), there is an ideation of what is intrinsic to wellbeing, the core of what 'well-being' means. Virtues, as previously discussed, are exhibited and inherent in people's behaviours, beliefs, and emotions. Core states, however, result when most of one's virtues underpinning one's being are positive rather than negative (Andreas & Andreas, 1994) as illustrated in much of the literature discussed in ancient religion and philosophy, as well as this dissertation.

The author draws on the definition of the five core states as being 'inner peace, love, okayness, and oneness' (p. 186) as offered by Andreas and Andreas (1994). Applying this to wellbeing, it is conceivable that in order for an individual to achieve wellbeing. They must discover which core state applies to their current behaviour before they can start being well in a state of wellness.

These conceptualisations of wellbeing all facilitate the need for the individual to recognise that wellness depends on the comprehension that it constitutes more than the physical. It is in fact a state of mind; it is recognition that one is well in one's being, and that one's being constitutes every element of life and thus the need to keep these elements in check.

Andreas and Andreas (1994:5) maintains that one is functioning within one's core self when one experiences wholeness, inner peace, wellbeing, love and aliveness. In turn, the individual is fully grounded and centred within their body, allowing them to be fully aware of the body and all their emotions. Through this, the individual gains a clear perception of the world and what they want to achieve, allowing them to behave in alignment with their virtues and values.

When individuals function with their core selves then, they act in their own best interests whilst respecting and acknowledging the interests of others. Through this they demonstrate a positive sense of self (which is not the same as a positive self-image), that is, an awareness of the self. The individual is resourceful and acknowledges that they have choices about feelings (emotions) and behaviour.

Somatic-focused and emotion-focused experiential traditions (Gendlin, 1981, 1996; Greenberg & Paivio, 1997; Greenberg et al., 1993; Levine, 1997; Perls, 1969; Rothschild, 2000; Safran & Greenberg, 1991) have documented how the psyche is transformed through the simple shifting of focus away from 'in-the-head cognition' and toward 'moment-to-moment in-the-body sensing' and feeling, (i.e., 'lose your head and come to your senses'), a process which restores access to the wisdom of the body and releases natural healing processes rooted in the body's basic adaptive strivings and self-righting tendencies (Fosha, 2004). This concept is similar to Emde's (1988) concept of 'wired-in' self-righting tendencies. Fosha terms core states as 'core affective states'; that is, that state of vital and spontaneous being when efforts to inhibit spontaneity (i.e., defence mechanisms) are not in operation.

Schwartz, a constructivist, describes a core state as the 'absolute ground of being' (1992, using what he deems to be the 8Cs to describe functioning under the aegis of the core self: confidence, calmness, creativity, clarity, curiosity, courage, compassion, and connectedness. It is Schwartz's contention that in order to deal with all the intense provocations to which one is subjected day in and day out (i.e., stress) and in order to keep firmly grounded, one has to tap into something at the core of one's being. In his view, the healing power of the self (Schwartz, 1992) and an awareness of the self brings about a state of deep mindfulness, full-bodied attention, centred awareness, and inner calm.

It is clear that the constructs of core states have been developed by practitioners with different histories in the field independently, via different conceptual and methodological therapeutic trajectories. However, the uncanny congruence of these constructs provides a corroboration of the validity and solidity of the phenomena.

Besides Dunn (1961), the phenomenon of a core state has been described by many, including Darwin (1872) and James (1902), along with practitioners of different spiritual traditions, Eastern and Western. However, the congruence between core state and core self-functioning is noteworthy because the construct is usually used to describe phenomena observed at the culmination of complex therapeutic processes. However, it is the author's contention that a prior knowledge of the construct aids the counsellor and provides a way of working with the client, deeply informed by the belief that the patient's capacities for healing transformation reside within the patient, and that the aim of any intervention is to entrain those capacities and to help change whatever is impacting on, or constraining, their wellbeing.

Thus, underlying the conditioned (due to societal norms) and often restrictive and limiting beliefs in that which individuals think of themselves, lies a core state of being which is unconditioned; the source of our aliveness, wellbeing, and sense of connectedness. At the heart of understanding core states is the belief that true healing is only possible to the extent that one can be fully present in the immediacy of one's inner beliefs (which comprise the set of virtues) and outer experience (in the relationship of the self to others and the spiritual dimension; i.e., to be mindful). Germer et al. (2005) define mindfulness as the ability to recognise what is happening in the present moment. Further, mindfulness is a skill that needs to be developed to allow one to be less reactive to what is happening in the moment, and relating to all

experience (both positive and negative) to reduce stress and acquire an enhanced sense of wellbeing. Thus the search for core states means reaching into the wellspring within to gain a sense of wholeness and wellbeing.

The proposed model is based in part on the five core states (Andreas & Andreas, 1994) and thus a discussion on each is necessary.

3.5.1.2.1. The five core states.

Love is conceptualised as not being aimed at a specific conceptualised object, but rather that it is all encompassing and transcends conceptualised boundaries. In other words, it is the ability to not only love oneself, but to also love one's place in the universe and everything contained within it. In this regard, love can be understood to be unconditional. 'Okayness', specifically relates to the view that the individual holds about themself as a functioning person. This means that an individual's self-worth transcends belief or judgement from other groups, beliefs, religious sects, or other understandings. It is a very deep sense of intrinsic worthiness that is not dependent upon the individual's external environment.

Whilst okayness is preoccupied with an individual's self-worth, being is the awareness of a person's own presence and experience of their reality. It does not correspond with judgments of others, nor is it a self-concept that is dependent upon labels, ideas, or beliefs. Rather, it is the individual's own experience of being in their own life.

Inner peace relates to the feelings of calm and serenity experienced by the individual, regardless of external environmental stimuli. This is different from being and okayness as it does not correspond with societal stressors but rather, it corresponds with environmental ones which may cause the individual harm.

Perhaps the core state that most directly responds to quantum physical understandings of is that of oneness, which is premised on the concepts of non-locality, downward causation, and tangled hierarchy. It is the understanding that a person's sense of reality allows them to perceive themselves as being separate from others and everything else, but in actuality is not the case. Oneness refers to the state of understanding that an individual is everything and yet nothing at the same time. It is the euphoria of absolute unity with life.

3.5.1.3. Core states and virtues

According to Andreas and Andreas, the ultimate core state of wellbeing consists of Love, Inner Peace, Okayness, Being, and Oneness. To accomplish the ultimate core state of wellbeing, the nine virtues need to be adjusted from the negative attitudes to the positive attitudes for each of the virtues respectively. Even though a client may exhibit maladjustment in any of the nine virtues, it is possible for the client to still exhibit certain ultimate core states of wellbeing.

3.5.1.4. Body systems.

A body system is a group of organs which symbiotically operate together to perform a certain physiological function. Several studies have illustrated the significance of virtues and their impact upon the body systems of people (Lloyd, 2011; Shilling, 2012).

3.5.1.4.1. The nine body systems.

The Wellness Questionnaire comprises an assessment of the individual's bodily systems. It consists of questions relating to the: endocrine, skin, gastro-intestinal, immune, central nervous, respiratory, reproductive, and circulatory systems, as well as the urinary tract and muscular/skeletal functioning.

3.5.1.4.2. Parts of the body systems.

Each of the body systems mentioned above relates to a specific part of body functioning. The endocrine system relates to the response through the release of hormones and or the flight or fight response. The 'skin' relates to responses the skin generates to dis-ease in the body, and the gastro-intestinal system is related to stomach responses. The immune system is the system that fights infections and is directed by the central nervous system. The respiratory and reproductive systems and the urinary tract involve the process of breathing, reproducing offspring, and excretion, respectively. The circulatory system concerns how chemicals and blood are regulated within the body, while the muscular skeletal functioning relates to movement.

Goswami (2011) has illustrated the relation between physiological locations in the body and energy impacting on emotional, thinking, and belief states. Furthermore, there is substantial evidence that locates dis-ease in the biological areas of the body (Woods, Natterson, & Silverman, 1996 in Rankin, 2013; Siegel, 1986 in Rankin 2013). Hence, problems relating to the functioning of a body system correlate to problems of thinking, believing and acting and vice-versa – our virtues impact our bodies and our bodies impact our virtues.

3.5.1.5. Body systems and virtues.

Various literature (Loyd, 2011; Shilling, 2012) indicates correlations between virtues, body systems, body symptom parts, and symptoms and problems, for instance, love is correlated with the endocrine system; joy, with skin; peace with the gastro-intestinal system; patience, with the immune system; kindness, with the central nervous system; goodness, with the respiratory system; trust, with the reproductive system and urinary tract; humility, with circulation; and self-control, with the muscular/skeletal system.

3.5.1.6. Core states and the well-being and dis-ease or illness continuum.

The achieved ultimate core states of wellbeing or lack thereof indicate where the client is located on the Disease or Illness and Wellbeing continuum at present by means of the quantitative significance of positive vs negative attitudes. The continuum is dynamic and not static meaning that the client may be at either side of the continuum in a direction of either disease/illness or wellbeing.

***Figure 0.1*: Illness-Wellness continuum**

3.5.2. Measurement.

These questions are subcategorised randomly within the questionnaire in order to calculate the quality of the nine virtues (Love, Joy, Peace, Patience, Kindness, Goodness, Trust, Humility, Self-control) in terms of two opposing categories. The categories consist of positive and negative attitudes subcategorised into unforgiveness vs forgiveness, harmful behaviours vs healthy behaviours, and unhealthy beliefs vs transforming beliefs.

3.5.3. Purpose.

The severity of somatic complaints indicates the location on the disease/illness and wellbeing continuum, whereas the virtues and ultimate core states of wellbeing determined by attitudes determine the direction of the client's wellness on the continuum. Therefore, it is possible to determine the direction in which the client is

facing on the continuum and provide an indication of the location of the client on the continuum.

3.5.4. Application.

Clinicians using the wellbeing questionnaire will be able to locate where the client stands in terms of their wellbeing and the direction in which they are currently facing. Clinicians, counsellors, and healthcare practitioners can draw upon this in determining effective strategies that can assist with facilitating the client's well-being as well as being an instructional tool to pace and lead them towards wellbeing.

3.6. Conclusion

As this method stands, several criticisms of modern wellness/ well-being models are curtailed. The use of the QSDA and CSMP allow the quick identification of any immediate barriers for clients seeking counselling as well as offering counsellors a means to rapidly refer a presenting case. Furthermore, the Wellbeing questionnaire advocates a form of well-being counselling that shifts the focus from a dimensional outlook of lifestyle to the virtues one displays, making it more congruent with truly holistic wellbeing. Furthermore, the role of patient-responsibility is understood in the Well-Being Questionnaire as a form of psycho-education where clients are led by the counsellor to becoming responsible for their own wellbeing decisions.

Chapter 4

The role of wellness in the social welfare

4.1. Introduction

The objective and the extent of social work has been created to assist individuals in a community and bring changes to communities by creating strategies that seeks to help individual to have value in their society and by creating atmosphere of total wellbeing for marginalized individuals. This is achieved by uplifting the lives of the downtrodden in the society and transforms them to a place where they have dignity and self-love.

Like in any profession or sector, the social work sector has got some terminologies that are used on day to day basis. These terminologies have been created for the purpose of understanding what needs to be attended to, at a certain point. This assignment will discuss some terminologies that are related to wellness counseling and how they should be utilized within the context wellness. This chapter reflects on government social welfare document.
https://www.gov.za/sites/default/files/gcis_document/201409/whitepaperonsocialwelfare0.pdf

4.1.1. Terminologies used in the social work sector and their relevance to wellness counseling.

a) **Early childhood development**: This term combines concepts that involve multiple of sectors; health, social protection, nutrition, socio-emotional development of children, physical, cognitive, education and language. The definition of ECD addresses the wellbeing of children up to age 8 to 9 years mentoring them for readiness school and other needs of young children in early grades.

This term is related to wellness counseling in that wellness counseling, in its design brings awareness to communities about various needs which include all of the above as stated under the definition of the above term. Health, nutrition, physical heath and socio-emotional are in core scope of wellness practitioners therefore this particular term is relevant in that sense.

b) **Child abuse and neglect:** child abuse is not just physical scars in a child, it entails multiple of abuse such as emotional maltreatment, sexual abuse, neglect (physical and financial neglect), prostitution and pornography.

All these forms of abuse leave damages to children. Any form abuse needs some kind of intervention in one way or the other, quite often the setup of our healthy system design, is in a way that seeks to address one part of the problem of a child challenge. This opens up space for wellness counselors to holistically intervene in a cases where social workers are restricted, for instance a social worker may not have knowledge on how a physically abused child need to be assisted at an urgent basis, a wellness counsel may have knowledge on utilizing home remedies and supplements. This shows that child abuse and neglect term is related to wellness counseling.

c) **Appropriate social welfare services and programs:** social welfare services and programmes addresses challenges such as; Reconstruction and Development, the white paper for social welfare, Growth, Employment and Redistribution (GEAR) ,Cash transfer for children, Old-age pension, Disability grant, War veterans grant, Unemployment Insurance (UI) and indigenous approaches. This is sector is related to wellness counselling because the practice of wellness is centred around indigenous approaches, for instance, the use of folk medicine is an indigenous approach which falls under the scope of ethno-medicine.

d) **Household food security;** access to food is one important aspect life to human beings. Without food security, a society may find itself having its inhabitants suffering from malnutrition. Food security should not only focus on the abundance of food but should also focus on educating the people on the proper food diet.

This term is related in wellness approach in the sense that holistic practitioners are involved in educating its society on proper nutrition which include the use of herbs and supplement.

e) **Mental disorder:** This refers any illness which is associated with psychological or behavioral abnormalities which often manifest itself with a painful or distressing symptom. Such people often are often secluded from society participation as a result of their impairments.

The practice of wellness practitioners is essential to people affected by such illness. Often times the people close to such people needs assistance in the form of natural remedies and counseling hence this is also related to wellness counselors.

f) **The mental health promotion:** focus on improving of psychological wellbeing on individuals or groups by developing value and wellbeing to the affected.

This term is related to wellness counseling because wellness counseling focuses on the total wellbeing of a person by bringing awareness within the ground level other health sectors find it difficult to operate.

g) **Nutritionally vulnerable:** People can be nutritionally vulnerable as a result of various reasons. People or groups that may be exposed to nutritional vulnerability includes all sort of groups in society; children, young, the aged, poor, and homeless people. Lack of good diet has an impact on long-term health consequences; increases non-communicable disease prevalence, healthcare costs, and disease burden; and negatively impacts lives of people in the society.

This term is related to wellness counseling because, part of the scope of wellness practice is the involvement to community coaching particularly with regard to good nutrition. A social worker may not possess knowledge on good nutrition but wellness counselor's scope allows them to function on this regard.

h) **Private practitioners**: psychologists and social workers are private practitioners in the human services sector. They provide services for a fee. This means that they are independent and in some cases are not even paid by the state. Wellness counselors as it is now are not integrated into the health system as expected. They are currently obliged to operate as private practitioners and charge a fee to their clients.

i) **Social security**: these are formulated policies which are made for ensuring that citizens are socially and economically protected in times of unemployment, ill health, maternity, orphans, widows, disabled and the aged by providing them with assistance for their needs, such as government grants and assistance from non-governmental organizations and faith based organizations.

This is relevant to wellness counselors as it entails some social needs for the people. Wellness practitioners get involve in matters of social needs for the society by providing counseling and spiritual guidance to socially challenged individuals.

j) **Substance abuse:** this refers to the misuse or abuse of substance whether legal or illegally such as nicotine, alcohol, over the counter and prescribed drugs, indigenous plants, solvents, and inhalants.

The fact that some people use this thing without having knowledge about the side effects or using them as some sort of relaxants as a result of stress or peer pressure; it clear indicates can that there is a need for wellness counselors to bring awareness to these people. There is a gap where wellness practitioners can be placed as area of operation. Drug abuse in the rise all over the world, governments is failing to tackle this pandemic. It will therefore be recommended that that wellness counselors should incorporated in the health system to assist in tackling this challenge.

4.1.2. Conclusion

It is clear from the discussed terminologies that there is an overlapping relation between the work of the social work and wellness counseling. It has also been established that scope of practice of the two professions are related to another, in the main of it helping individuals in the society by means of counseling, education, integration and other social welfare needs.

4.2. Elements of Social work for wellness counselors in the context of welfare

4.2.1. Introduction

South Africa is arguably one of the best countries in the continent that have developed social security policies and systems. It has created and formulated some world class health accessibility frameworks and yet the actual social work deliveries do not meet the needs of the society.

This assignment seeks to identify some of the challenges within the welfare system and also make some recommendations to the identified challenges. The following critical problems have been identified within the welfare system:

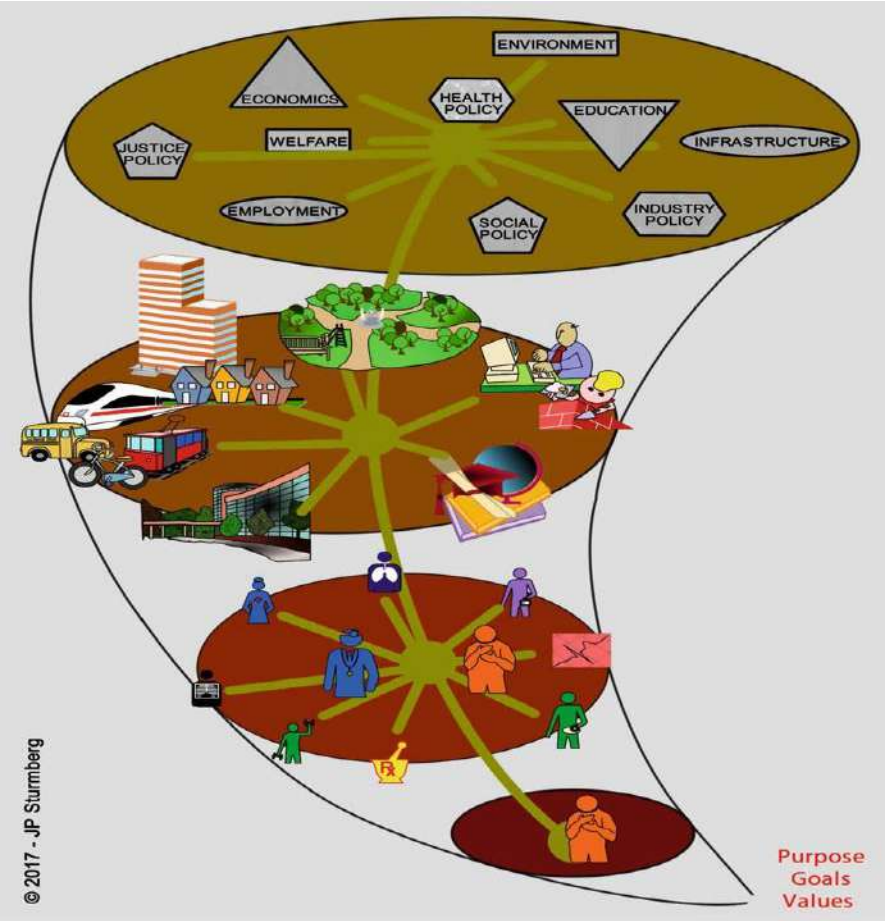


Figure 4.1.

4.3. Lack of national consensus

There is no national consensus on a welfare policy framework and its relationship to a national reconstruction and development strategy.

- In any country, it is unlikely that its citizens can agree in every policy direction, while this may be the case, it is the duty of the state to ensure that the society is well informed about government policies and initiatives. This can be achieved through **continuous campaigns and training**. In order to achieve national consensus, the state needs also to **promote** citizens **participation** to its programs.
- Secondly, governments, together with all stakeholders including the social development department and department of health in particular should upgrade national policies by introducing new ones that promote citizens inclusion.

- The state needs to understand that collaboration application can be achieved through the promotion of consensus. This two-work hand in hand and it can unlikely to be achieved unless information is given to the people on continuous basis. Through Consensus; the society automatically willingly participates in projects that seek to address their welfare predicaments. Another benefit of consensus is that it improves informed decision making and it important to ensure that is it pursued in order to persuade members of the society who might be having a different view.

4.4. **Disparities**

Past welfare policies, legislation and programmes were inequitable, inappropriate and ineffective in addressing poverty, basic human needs and the social development priorities of all people. Racial, gender, and geographic disparities have created significant distortions in the delivery system. In general, welfare service provision has an urban and a racial bias. Services are not always located in underprivileged communities and are therefore inaccessible to their members.

- The remedy for this problem is that government should design implementations procedures that are responsive to the people's needs.

4.5. Information

Information is fragmented and incomplete, leading to an inability to understand the need, impact or consequences of welfare spending.

- This can be corrected by creating community-based information centers that are on the ground level and easily accessible by the community. Social workers personnel have to be continuously trained to enhance their skills in to be adequately responsive to its citizens.

- Social workers personnel have gone to where the people are; home visits, public campaigns and involved other healthy practitioners like the wellness counselors.

4.6. Fragmentation

The welfare system was administered by 14 different departments for the different population groups and homelands. This resulted in fragmentation, duplication, inefficiency and ineffectiveness in meeting needs. Each of these departments had their own procedures, styles of work, approaches and priorities. There is a lack of inter-sectorial collaboration and of a holistic approach. This fragmentation is also reflected in social welfare legislation.

- The remedy for this will be establish only one national welfare department, streaming down to provincial and to local government level and accelerate service delivery.

4.7. Participation

Participation of the society and all stakeholders in decision-making on social welfare policies, programs and priorities was not exercised fully and effectively. This resulted in a lack of legitimacy in the welfare system. The following constitutes an approach to best Practice in societal participation:

- **Societal Participation:** It includes initiatives on educating the citizens including campaigns and public consultations (both on how the process should be achieved and on the substance of the act /legislation) through national dialogue.
- **Representation and Inclusion**: An inclusive process will attempt to draw in all key stakeholders to the process. Efforts should be made to reach out to marginalized sectors of society, including women, young people, people with disabilities, ethnic/religious minorities and indigenous groups, older people, poorer socio-economic and disadvantaged groups, and migrants and non-citizens formally resident in the country.
- **Transparency:** one of the biggest enemies of societal active participation is the failure for the state to be transparent; it is common knowledge that in recent times, there is lack of trust between the society and government hence lack of participation is on the rise. Information about processes, appointments, and consultations timelines should be clear.
- **National Ownership**: This principle requires government to go beyond party politics lines. Currently there is lack of national ownership because government fails to convince the citizens that the policies, they are pursuing are national agenda as opposed to party politics. National ownership can be achieved by developing representative governance

structures to build up the partnership between Government, organizations in civil society, religious organizations and the private sector.

4.8. Inappropriate approach

The social service delivery system is organized along specialist lines. It is fragmented between a number of fields of service, which did not always allow for a holistic approach. While some social workers have received training and practice in community development, the approach to service delivery is still largely rehabilitative, it relies on institutional care and is not preventative and developmental. Welfare services are not accessible and responsive to the needs of all people. There is a lack of personnel to address needs, especially in provinces with large rural areas. Other categories of personnel are underutilized. A significant proportion of existing personnel are not trained in developmental approaches.

- Restructuring the partnership between stakeholders to develop a system which is socially equitable, financially viable, structurally efficient and effective in meeting the needs of the most disadvantaged sectors of the population, and to involve communities in planning and the delivery of services.

4.9. Lack of sustainable financing

In the past, social welfare programmes were not considered to be critical social investment priorities and were under-resourced.

- Developing a financially sustainable welfare system can remedy this mishap. This can also be made possible by making this sector a priority when national government does its yearly budget.

4.10. Lack of enabling environment

There is a lack of enabling legislation and taxation policies are not "welfare-friendly".

- The remedy for these challenges can reversed by developing strategies and mechanisms to translate the aims, objectives and programmes of the Reconstruction and Development Programme into action in the welfare field. The development of intersectoral arrangements within the welfare sector and between the welfare sector and other Government departments is a key priority.

4.10.1. Partnership

South Africa has a fairly developed social security system and a rich institutional framework of welfare services delivered by non-governmental organizations, such as voluntary welfare organizations, religious organizations, community-based organizations and informal family and community networks. These organizations

have expertise, infrastructure and other resources which could play a significant role in reconstruction and development.

- Human resource development and the re-orientation of personnel where this is necessary towards establishing a developmental social welfare framework.

4.10.2. **Conclusion**

The South African social welfare system is characterized by the need for the transformation of services and the need for the promotion of service integration among different stakeholders. In the context of the wellness counseling, transformative processes brought by political reforms that were previously introduced should be improved. It is also clear that there is lack of national participation as a result of government to create inclusive guidelines to its policies. This has resulted in non-societal participation from the marginalized who perceived to be excluded in the planning and implementation processes. The lack of society trust against government as the result of rampant corruption has also caused a mistrust between government and the society. It is also clear that government is now failing to address societal issues by lacking to promote partnership between stakeholders; wellness counseling, religious leaders, local government, social welfare and other government departments.
https://www.gov.za/sites/default/files/gcis_document/201409/whitepaperonsocialwelfare0.pdf

4.2. Social PROBLEMS AND AREAS OF NEED

South Africa, like many other developing countries, is beset by serious social problems that requires a government structured, society driven concerted effort to address. Some of the most pressing social problems include the following:

4.2.1. Lack of healthcare and counselling services and facilities

With a population of almost 60 million, SA is the 25th most populated country in the world with almost half of the people unemployed. This leads to high crime rates and insufficient healthcare facilities. This situation provides the space for wellness counsellors to work in structured and supervised environments including, but not limited to private and government Institutions, schools, Non-Governmental Organisations including Faith Based, Community Based and Not-for-Profit Organisations, the South African Police Service, Counselling Call Centres, Hospitals, Clinics and Support Agencies, Sports Centres, Education and Training facilities, Health and Emergency services and facilities. With insufficient numbers of available healthcare workers and many people that cannot afford to belong to medical aids schemes, wellness workers fulfil a much-needed function by working in a variety of needy contexts, often in environments where mental health professional such as psychologists and social workers are not necessarily accessible to the majority of the

population. They make an important contribution to social work in terms of counselling that enables one or more people to go through the process of finding solutions to their concerns or difficulties. Counselling may take various forms, including with individuals, couples, families or domestic units and groups. The Further Education and Training Certificate: Counselling Qualification will allow counsellors to be recognised and will address current national health and social service priorities. Ideally, qualifying learners will operate under supervision.

4.2.2. Lack of dignity, safety and support

The occurrence of domestic violence has always been alarmingly high in South Africa. Though domestic violence is not limited to female members of the family, statistics show that women are most affected by this form of violence. In many domestic violence cases women and girls are often battered and even killed by their partners/relatives. Fear of abandonment often prevents women from reporting violence on themselves. Incest and abuse are most commonly practiced in families where the father is the only source of income, because the entire family is dependent on him. In this situation fathers subject their daughters or stepchildren to sexual abuse and often the incidents are not reported to the police or sometimes even to their mothers. If the incident is reported to the child's mother, she would often not report it to the police for fear that the father would victimise her or withdraw the resources that keep the family going. This suggests that poverty and bad socio-economic conditions (like unemployment and overcrowding) play an important role in silencing abuse victims. It should be highlighted that women are not only abused by people familiar to them. They are also exposed and vulnerable to abuse by strangers. It is widely (though completely falsely) believed that sexual engagement with a young child or virgin can cure HIV/AIDS. This exacerbates the exploitation of young girls and virgins by strangers and family members alike. In spite of an intensive campaign to discourage people, this disgusting exercise is perpetuated. Women victimised by strangers are mostly those without good infrastructure. In 1996, in an attempt to address the state of affairs, the government introduced the Domestic Violence Act (Act 116), with the objection of providing protection to women against domestic violence and abuse. The Act outlines behaviour that constitutes domestic violence including physical, sexual, verbal, emotional and psychological abuse; stalking, intimidation, harassment, malicious damage or unauthorised access to the complainant's property; as well as other forms of controlling behaviour which may cause harm to the safety, health or wellbeing of the complainant. The Act allows women to approach the court to apply for a protection order against their abusive partners and prohibits an abusive partner to commit any action of domestic violence. Fortunately, many NGO’s are stepping in to help relieve the problem. There are vibrant Nongovernmental Organisations, like People Opposing Women Abuse (POWA) and Women Against Women Abuse (WAWA), which were established in 1979 and 1989 respectively, to educate and support female victims of assault and rape. Safety and security are a big issue in South Africa with so many hijacks and murders being committed in black townships and on farms. This underscores the need for trauma counselling where wellness counsellors can partake in interventions. The government has also released a White Paper for Safety and Security. The White

Paper provides the means of realising our vision of improving the safety of our citizens.

4.2.3. Poverty

The government aims at social welfare policies and programmes to be developed which will be targeted at poverty prevention, alleviation and reduction and the development of people's capacity to take charge of their own circumstances in a meaningful way. Individuals, families and households are particularly vulnerable to poverty in times of unemployment, ill health, maternity, child-rearing, widowhood, and old age. Disability in a family also increases the impact of poverty. Further, economic crises, political and social changes, urbanisation, disasters or social and political conflict and the displacement of people contribute to, or heighten the distress of poverty. Adequate social protection will be provided for people who are impoverished as a result of these events. Poverty coincides with racial, gender and geographic or spatial determinants, and these will be taken into account in the targeting of programmes. While poverty is widespread throughout South Africa, African people are most affected. Women and children (particularly in female headed households), people with special needs, and those living in rural areas, informal settlements and on farms, are most at risk and will be assisted. Poverty is often accompanied by additional social problems, such as family disintegration, adults and children in trouble with the law, and substance abuse. It is the combination of economic-mic, social, and emotional deprivation which heightens the vulnerability of poor individuals and families. Appropriate programmes will be implemented to enhance social integration. Support and assistance (such as restoring dignity and self-esteem, the promotion of competence and empowerment programmes) will be provided for individuals and families to assist them to break out of the structural barriers which keep them in poverty. Poverty is often accompanied by low levels of literacy and a lack of capacity to access economic and social resources. The welfare departments' developmental social welfare programmes will build this capacity, facilitate access to resource systems through creative strategies, and promote self-sufficiency and independence. Innovative strategies will be designed for vulnerable individuals and families to increase their capacity to earn a living through employment creation, skills development, access to credit and, where possible, through facilitating the transition from informal to formal employment. Special programmes will address the needs of vulnerable households and help them access both governmental and non-governmental employment programmes. Employment programmes for people with special needs will always be necessary and will be provided. Poverty also places strains on household resources and on family and informal networks, which increase the need for formal social welfare services. Existing family and community networks will be developed and strengthened. Poverty is one of the most important causes of hunger and malnutrition, which contribute to illness and disability. Social welfare departments will appropriate incorporate nutritional objectives and activities into their relevant components. The welfare departments will also collaborate with other government departments to ensure that these programmes are effectively targeted at those who are vulnerable to malnutrition and at the socio-economically deprived in the form of supplementary

feeding, public works, capacity building and other developmental programmes which will contribute to household food security. Welfare departments will co-operate with health departments in their supplementary feeding programmes for children and women. The nutritional needs of other vulnerable groups such as the elderly will also be addressed. Structural poverty emanates from the economic, political and social organisation of society. Unjust legislation and inequitable policies and programmes of the past have also contributed to increasing levels of poverty. In view of the structural causes of poverty, an intersectoral response is needed. The Department of Welfare will collaborate with other government departments and nongovernmental organisations and institutions to develop an integrated response to poverty. In view of the widespread rural poverty, a rural development strategy will be developed by the Department of Welfare in consultation with all the relevant role players, which will increase the access of rural people to developmental social welfare programmes. An overarching anti-poverty programme will need to be developed which requires the cooperation between government departments and non-governmental organisations.

4.2.4. Discrimination and lack of equity

All forms of discrimination in the social welfare system will be eliminated in accordance with the Constitution of the Republic of South Africa. Religious, cultural and language rights will be accommodated in accordance with the Constitution. Creative strategies to address racial inequalities will be considered, e. g. taking services to the people; exploring the use of mobile units; bussing people to service points if this is cost-effective; networking between communities to find solutions; strategic planning and change management interventions; mediation and dispute resolution; cross-cultural education; breaking down racial stereotypes, barriers and social distance between groups; and the exchange of resources. National and provincial plans will be devised in consultation with stakeholders to phase out racial discrimination. Such plans will have detailed targets, time frames and monitoring procedures. Minimum criteria for the delivery of welfare services will also be developed. Governmental and non-governmental organizations will create equal opportunities for people with disabilities. Appropriate programmes will be developed to enhance their independence and promote their integration into the mainstream of society. Social welfare policies and programmes will be devised to become more gender sensitive and to address the special needs and problems of women. The national and provincial departments of welfare are committed to providing services while they orient themselves in new directions. The reorientation process will take place alongside the existing system and the new system will be phased in immediately.

4.2.5. Lack of community development

Social workers are involved in community development programmes. Community development strategies will address basic material, physical and psycho-social needs. The community development approach, philosophy, process, methods and skills will be used in strategies at local level to meet needs. The community development approach will also inform the reorientation of social welfare programmes towards comprehensive, integrated and developmental strategies.

Community development is multi-sectoral and multi-disciplinary. It is an integral part of developmental social welfare. The focus of community development programmes in the welfare field will be on the following:

(a) The facilitation of the community development process.

(b) The development of family-centered and community-based programmes.

(c) The facilitation of capacity-building and economic empowerment programmes.

(d) The promotion of developmental social relief and disaster relief programmes.

(e) The facilitation of food aid programmes in emergency situations owing to disasters such as floods, fire, civil unrest or drought, or to alleviate acute hunger. Food aid of this nature will be a temporary measure until individuals and households can be incorporated into other social development programmes.

(f) Voluntary participation in social and community programmes will be actively encouraged and facilitated.

(g) Self-help groups and mutual aid support programmes will be facilitated where needed.

(h) Advocacy programmes will be promoted.

(i) The Government will facilitate institutional development with the focus on creating and/or strengthening existing Government institutions and organisations of civil society.

(j) Appropriate public education and non-formal education programmes will be facilitated.

(k) The promotion of community dispute resolution and mediation programmes will be embarked upon where needed. Training programmes will be provided.

(l) The access of local communities to governmental and non-governmental resources to address needs will be facilitated.

(m) Intersectoral collaboration will be promoted, while the separate functions of different sectors and Government departments will be acknowledged. A range of social development workers will be employed to address different needs and problems and to increase human resource capacity, particularly in under-serviced communities and rural areas. Effective training programmes, accreditation systems and the definition of the roles and responsibilities of social workers and other categories of personnel will be developed. There will be scope for some social development workers to perform specialised roles while others will be more generic or development-oriented. A task group will be established to develop volunteer programmes at national and provincial levels. These programmes will be developed in consultation with all stakeholders in order to increase human resource capacity in the delivery of developmental social welfare services and programmes.

4.3. RESTRUCTURING PRIORITIES.

4. 3.1. Introduction

The need to formulate policies of the social welfare is urgently needed because the society is transforming at a rapid pace and social welfare practitioners ought to do the same to provide the optimum support to their communities. Social welfare practitioners are often introduced to cases centered on violence, substance abuse, isolation, inequality and more. With experienced, proper training and a positive mindset, the social welfare sector has to develop restructuring guidelines in order to address challenges such as; lack of national consensus, disparities caused by previous welfare policies which were inappropriate, fragmented and incomplete information, lack of citizens and stakeholders participation in decision making, inappropriate approach to service delivery implementation, lack of sustainable financing, and lack of partnership with private and non-government organizations.

This essay seeks to provide solutions to the challenges facing the social welfare by clarifying the role which must be played wellness counselors through the following restructuring priorities which have been identified;

4.3.1.1. Building consensus about a national social welfare policy framework.

Consensus in decision making is a creative and dynamic way of reaching agreement between all members of a group. Instead of simply rubber stamping for an item and allowing the majority in discussions getting their way, a policy making committee using consensus is committed to finding solutions that everyone actively supports, or at least can live with. This ensures that all opinions, ideas and concerns are taken into account. Through listening closely to each other, the committee aims to come up with proposals that are rational and work for everyone as opposed to a group of people.

By definition, in consensus no decision is made against the will of an individual or a minority. If significant concerns remain unresolved, a proposal can be blocked and prevented from going ahead. This means that the whole team has to work hard at finding solutions that address everyone's concerns rather than ignoring or overruling minority opinions.

Consensus should be adopted and used by our law makers and those tasked with implementing policies. it is regrettable that in South Africa the party representation system is working in contrary to this method. Decisions are lobbied along party lines and proper engaging with the society is often ignored. Unless the current system of majority rules ceased from being abused by those that get elected in high decision positions; the challenges faced by society will continue worsening. There is a need to properly consult with all stakeholders in in the social welfare sector including wellness counselors.

4.3.1.2. Creating a single national welfare department as well as provincial welfare departments and exploring the potential role of local government in service delivery.

One the problem of the current social welfare set ups is that there seem to no cohesion between national, provincial and local welfare departments. These detachments from these departments lead to a situation where there are no uniformities in terms of implementing necessary policies. Also, the distance between the departments of health creates some unnecessary challenges. Wellness counselors can play a role in ensuring that this gap is narrowed. Wellness practitioners should be given a platform that will enable them to work together with local clinics, hospitals, and social welfare departments.

4.3.1.3. The phasing out of all disparities in social welfare programs.

Disparities are common challenges in the society today. There has been much legislation that has been formulated to address this challenge, whether; it is health, education or economic inclusion. One can accept that this is a serious problem that needs an honest government to acknowledge its failures. The development of representative governance structures that will include wellness practitioners can assist speeding this process.

4.3.1.4. Developing representative governance structures to build up the partnership between Government, Organizations civil society, religious Organizations and the private sector.

Wellness counselors must be included in the representative governance because they the needs of the society as they work closely with them.

4.3.1.5. Restructuring the partnership between stakeholders to develop a system which is socially equitable, financially viable, structurally

efficient and effective in meeting the needs of the most disadvantaged sectors of the population, and to involve communities in planning and delivery of services

The current state of both the social welfare and health sector does not have a partnership with other relevant stakeholders such as holistic practitioners. Wellness counselors by nature of their operation can play a vital role in partnering with social welfare and play an advisory role in the restructuring process.

4.3.1.6. Legislative reform at all levels of Government.

Legislation reform at all levels of government may not be feasible in a short and medium period as this requires a complete overhaul of our system and this may require to change even the constitution of the land.

4.3.1.7. Human resource development and the re-orientation of personnel where this is necessary towards establishing a developmental social welfare framework.

There is a general concern that there is lack of proper training to public servants. This applies to almost sectors of government. The state can have good policies but if the people who are supposed to implement these policies are not familiar with them, it counts nothing. The correct interpretation of policies requires continuous training of the relevant people. A developmental social framework requires the inclusion of wellness practitioners of the elements of Social Work for Wellness Counselors as the have been long ignored even though there are legislations that deals with their establishment and inclusion.

4.3.1.8. Restructuring and the rationalization of the social welfare delivery system, towards a holistic approach, which will include social development, social functioning, social care, social welfare services and social security programs.

There is no doubt about the need to restructure the social welfare system. The national health insurance has tried address some of these concerns but there are still some outstanding issues which it did not address for example the role which Traditional practitioners, religious personnel as well as wellness counselors has to play.

4.3.1.9. Developing a financially sustainable welfare system.

The question as to whether health systems will be financially sustainable in the future is frequently raised in health policy debate. The problem is often phrased in terms of the ability of governments and others adequately to finance health care in the face of growing cost pressures, with population ageing, new ideas, technologies and consumer expectations around health care coverage and quality being the three most commonly cited challenges. Although the notion of ‘financial sustainability’ appears to be central to health policy debate, it does not form part of most health system objectives, including those of the national development plan (NDP) and the national health insurance (NHI) performance framework. Moreover, there is little clarity or consensus about the term's meaning, beyond it having something to do with ‘ability to pay’ or ‘affordability’. Nevertheless, the underlying ‘sustainability’ issue balancing rising cost pressures against limited resources is a concern across countries, all the more so in the context of the current financial crisis. Inevitably, this means addressing trade-offs, both within the health sector itself and more broadly between the health sector and the rest of the economy. The failure for our government to speedily implement the traditional health practitioners Act of 2007 has led to the overburdening of our public health care system. There is a need to fast rack the implementation of this Act as this will alleviate the dependency to public health care.

4.3.1.10. Developing strategies and mechanisms to translate the aims, objectives and programmes of the Reconstruction and Development Programme into action in the welfare field. The development of intersectoral arrangements within the welfare sector and between the welfare sector and other Government departments is a key priority.

The national development plan (NDP) (2012), primary health care (PHC) re-engineering (2011), and NHI (2017) policies are well drafted with beneficent intent. These policies provide the overall vision and strategies for South Africa to pursue

equitable health care for all. Nonetheless, these policies fall short in that there is disconnection between them and that they are not translated into synchronized strategic plans to produce sufficient numbers and more equitable distribution of health care. Aligning the policies and expediting their strategic implementation are essential to reach the desired goal of universal health coverage (UHC) through NHI and PHC re-engineering, and to fulfill the 2030 NDP vision of reduced health inequality and inequity.

4.3.1.11. An ability to translate these strategies and aims into implementable budgets requires better information and modeled alternatives so that decision makers can make more informed decisions.

According to national health insurance (NHI) document, South Africa already spends a very high amount on healthcare. If we add private and government spending together this amounts to more than R200 billion a year. A large slice of this is spent on private care for only 16% of the population. Private care at present is often needlessly expensive. NHI Fund will be able to count on all the present government funding for public healthcare all the money government spends on tax subsidies for medical scheme members Contributions from people who are presently members of medical schemes Contributions from those who earn well but have avoided joining medical schemes The NHI Fund income will amount to at least as much as present healthcare spending. But it is possible that government will be required to further boost this amount. The NHI Fund will have strong buying power which will enable it to purchase health services at a reasonable rate, the rate at which the NHI Fund will pay healthcare providers will be higher than the present cost of public health services but lower than the most rates in the private sector. The NHI Fund's method of payment will encourage healthcare providers to operate efficiently and provide effective care. The NHI Fund will be a non-profit body and will keep administrative costs low. https://www.hst.org.za/publications/NonHST%20Publications/Booklet%20-%20Understanding%20National%20Health%20Insurance.pdf

4.3.2. Conclusion

Since the beginning of democracy in 1994, the South African Legislatures have been paying attention on getting rid of unconstitutional laws, establishing transformative laws, building democratic and transparent legislatures responsive to the demands of the transformation agenda, and overseeing the establishment of new institutions to

promote democracy and human rights. A strong emphasis was placed on the function of law-making. In the second decade of democracy, the focus has shifted to the effective implementation of policies and laws, and overseeing delivery on the ground which is failing to meet the required targets as things stands. In the third democratic Parliament (2004-2009) there was an active move towards strengthening the core functions by developing strong oversight and public participation strategies within the Legislative Sector in line with its constitutional mandate. The strategic focus also shifted to strengthening the Legislatures of South Africa to ensure that they become the backbone of a successful representative and participatory democracy. Through the national assembly, Parliament and the provincial legislatures resolved to organize as a legislative sector and engage in efforts aimed at asserting the sector against potential threats to its independence. This has been done with due regard to the autonomous nature of all Legislatures. The SA Legislative Sector has an obligation to facilitate public participation and education. In order for effective education and public participation to take place, it is essential that the South African's Legislative Sector is able to function within a structured framework of participation that is aligned, transparent, and accountable and which promotes fundamental democratic rights and social justice. In keeping with this vision, the South African Legislative Sector has attempted to engage stakeholders' forms a key element of the development of such a Public Participation Framework. This attempt has been slow in implementation and has been hampered by the lack of national consensus, lack adequate information and rapid corruption which has resulted to a low public participation moral. Currently, the focus has shifted from implementing these policies to dealing with corruption particularly in the public sector. Policy initiatives such as the NDP, NHI and other social welfare related policies seem to have been stalled.

4.3.3. Recommendations

From the content of this reflection essay, it has been established that various areas of action have been highlighted that will support and enable the various policy makers to better align their practices with regards to the needs of the society, thereby integrating the legislative sector further. In particular, recommendations for implementation of these various areas of action at a high level can be categorized as follows:

• **Structuring policy and related social welfare**: Each individual decision-making organ needs to review their current policy in terms of the feedback provided in this reflection in order to fill the gaps that have been outlined. These gaps derive from various needs identified in the social welfare sector. This step alone will bring a degree of integration into the identified gaps across the sector. This alone will not achieve the ultimate integration and cooperation that is envisaged as part of this reflection objective. In order to achieve a more fundamental level of integration and consensus and public participation in the social welfare sector, the various elements of the policies and how they are interpreted, applied and practiced, will need work-shopping, discussion and agreement of sector practices that can be amended by each legislature in order to align the practices more closely. It is recommended that government would have the mandate to begin this and cascade any feedback into

each legislature's policy framework, manual and templates, into the up-skilling of managers and retraining of key staff to carry these changes through.

• **Implementation of the Traditional health Act of 2007**: The implementation of this Act will address some of the discussed challenges speed up the implementations of priorities. The current congestion, poor condition of our public health hospitals, and ignored integrated health system will be addressed by the establishment of wellness counselors within the primary health sector. This in turn could be fed into the Monitoring and Evaluation processes within each of the legislatures thereby enabling better planning and evaluation of current initiatives and help to apply resources optimally.

4.5 ASPECTS OF A NATIONAL DEVELOPMENTAL SOCIAL WELFARE SYSTEM

4.4.1. Introduction

Intersectoral collaboration can be described as the joint partnership between government sectors, for example department of health working together with social development department. This may include representatives from private, voluntary and non-profit groups, to improve the lives of people. Intersectoral action takes different forms such as cooperative initiatives, alliances, coalitions or partnerships. Successful intersectoral initiatives have early engagement of potential partners from sectors outside a single sector, as well as from different disciplines and levels within a particular sector. impactful collaboration is more likely to occur when participants have a clearly outlined the goals, based on shared values and interests. It is important to recognize that participating partners often place value on different things; the aim of collaborative work is to find common ground and to generate collective action to improve health. Establishing this shared purpose allows partners to see how participation will help them to achieve their own mandate, as well as contribute to the larger good. Intersectoral action should be seen as pivotal, where each party achieves something, as opposed to a competitive exercise based on sectoral "ideology," where one sector is seen as benefiting from the work of others in fulfilling its own purpose.

Inter-sectorial definition

Intersectoral structure's refers to actions affecting social work outcomes undertaken by sectors outside the social work sector, perhaps, but not necessarily, in collaboration with the social work sector intersectoral is a major factor which influences that shape the social development of populations and the service delivery of social welfare inequities are located outside the social welfare sector. The fact that most of these influences remain outside of the exclusive jurisdiction of the social welfare sector, requires this sector to engage with other sectors of government and society to address the determinants of health and well-being.

4.4.1.1. Decentralization of service delivery

There is a need for a quick decentralization process to be undertaken by government. one of the challenges of our government is that there are no clear guidelines of the roles that various sectors has to function. People are often confused as to which department they

should seek assistance from. Wellness practitioners can play a major role in educating the society about the duties of each sector.

4.4.1.2. Quality services

The principles Alma-Ata that was agreed upon 30 years ago is relevant today as it was then. It states that “Health for all” by the year 2000 which was subsequently not achieved, and the Millennium Development Goals for 2015 was also not met in most low-income countries without substantial acceleration of primary health care. Factors have included insufficient political prioritization of health, structural adjustment policies, poor governance, population growth, inadequate health systems, and scarce research and assessment on primary health care. The following priorities for revitalizing primary health care should be implemented as suggested by the national health insurance; Health-service infrastructure, including human resources and essential drugs, the strengthening the traditional health care sector, and user fees should be regulated for primary health-care services to improve use. A continuum of care for maternal, newborn, and child health services, including family planning, need to improve. Community participation and community health workers linked to strengthened primary-care facilities and first-referral services are needed. Furthermore, intersectoral action linking health and development is necessary, including that for better water, sanitation, nutrition, food security, and HIV control. Chronic diseases, mental health, and child development should be addressed. Progress should be measured and accountability assured. All this points out to the fact that there is a need of human trained personnel of which this gap can be filled by the introduction of a holistic approach in these sectors.

4.4.2. Transparency and accountability

Accountability and transparency are important building pillars for governing democratic nations in recent years. Before discussing about how they benefit, its needs, and its importance we shall see what exactly accountability and transparency is.

Accountability refers to the concern and duty of government institutional workers to perform their activities in the best interests of the public and that institutional officials should take responsibility for their activities performed. The mechanisms by which government officials can be held responsible for activities against formed principles and rules is called legal accountability. For understanding it well we shall have an example here, Government has accountability for laws and decisions affecting public; a citizen has accountability for his behavior and actions.

Transparency can be defined as a situation in which government institutions and other supporting organizations are performed in open way without any secrets which may lead to corruption, so that the public can believe and trust that these organizations are honest and fair. In other words, it’s a concept of eradicating all barriers and enabling information access to public and facilitate procedures, rules and regulations that protects those citizens, and this reflects on the development of the nation. A democratic state needs accountability and transparency as fundamentals, with parliament executing a major role as regulator. Sometimes it will be assumed that parliament and its supporting organizations are the appropriate zones to eliminate political allegations, corruption activities and maladministration made. But it has often happened that various attempts to institutionalize a

culture of transparency and accountability have been avoided. Developing nations with democratic system have always challenged the symptoms of economic corruption.

Holistic or wellness counsellors are well placed to understand the damaged done by the above factors and since part of the duties of wellness counsellors is to bring awareness about the works of government to the communities, this must not exclude educating the society about damages done by corrupt and unethical politicians.

4.4.3. Accessibility

Access to basic social services is very limited in South Africa hence service delivery demonstration is the order of the day. The abuse of financial resources and lack of coordination by Government has left non-state actors, such as NGOs and faith-based organizations, as the key providers of essential social services in most of the country. As a result, social interventions in South Africa are fragmented, underfunded, and poorly coordinated, limiting real impact on the poor. Families living in remote rural areas lack access to essential services such as water and sanitation, health services, quality education for their children, and income-generating opportunities. A high percentage of the population does not have access to an improved water source, have no access to sanitation facilities, and high percent of the population lack access to healthcare services. Many South Africans also suffer from poor hygiene practices in rural areas and informal settlements, malnutrition, and food insecurity. Wellness counsellors can play a major in the following way;

i) Family coaching using multisectoral community agents to work directly with families, providing basic services, including behavior change counseling, nutrition supplements, and vaccinations, and linking families to existing services.
ii) A tailored family development plan, created based on a socio-economic survey that captures a family's particular vulnerability.

iii) A dynamic and integrated information management system, which analyzes each individual family's conditions and vulnerabilities, proposes key actions to be undertaken, and tracks progress over time.

iv) An opportunity Map an inventory of services available to the population through various service providers in the target area, which is used for referral.

4.4.4. Appropriateness

Social welfare programs, methods and approaches must be appropriate, will complement and strengthen people's efforts, enhance their self-respect and independence and should be responsive to the range of social, cultural and economic conditions in communities. The sustainable use of human, material and the earth's natural resources will be ensured for the benefit of future generations.

4.4.5. Ubuntu

Ubuntu is essentially about togetherness, and how all of our actions have an impact on others and on society. It is the common thread of the UN's Global Goals, and the motivation in the mission to end extreme poverty so that everyone, everywhere, can live equally. The scarcity of basic needs is becoming a huge challenge to developing countries, with food

security topping the list. The richer are becoming more richer while the poor are becoming poorer. This calls for the empowering of people through the revitalization of farming.

4.4.6. Engagement

The South African Constitution is underpinned by principles of good governance, also highlighting the importance of public participation as an essential element of successful good local governance. Section 152 of the Constitution of the Republic of South Africa,1996 confirms a number of citizen rights and more specifically, the rights of communities to be involved in local governance. Municipalities are obliged to encourage the involvement of communities and community organisations in local government. This obligation extends to the entire way in which a municipality operates and functions. The principle behind public participation is that all the stakeholders affected by a public authority's decision or actions have a right to be consulted and contribute to such a decision.

The municipality is obligated to:

• Take into account the interests and concerns of the residents when it crafts by-laws, policy and implements its programmes;

• Communicate to the community regarding its activities

• Public communication involves the municipality giving information to other stakeholders.

• Public consultation involves other stakeholders providing information to the council at the request of council or out of their own initiative.

• Public dialogue involves the mutual exchange of information between the stakeholders and council representatives.

• The participants should be representative of the target population. It might not be possible to include every member of the population but the aim is to strive to include all the known interests including trans-border concerns.

• The process should be independent of any political or funder's influences. Care should be taken to avoid relying on politically aligned local structures.

• There should be early involvement of the public. As soon as council has identified a need for policy, it should communicate the perceived need to the public.

• The inputs by participants should influence policy. For public participation to be effective, the public must have confidence that their contributions will influence decision making. Furthermore, the public must receive feedback on each outcome of their contribution.

• The process should be transparent. The process of participation should be communicated to all affected parties.

• Participants should access resources including materials, information, experts and sufficient time to make decisions. Council could establish timelines for engagement such that consultation is planned, anticipated and not ad hoc. The timelines should be shared with all stakeholders through the most relevant means.

• The purpose of the participation should be clearly communicated. The public should be aware if they are receiving, giving, and sharing information with council.

• There should be a predetermined and structured decision-making process communicated to all stakeholders. Residents should be aware of how their contributions will be processed and input into the decision-making process.

4.5. Conclusion

Access to public information and citizens' participation in the decision-making process of the public administration are most crucial elements of open public administration. In this regard the principle of transparency in public administration involves many other principles that are influencing the process of transformation toward open and good governance. The accomplishment and implementation of this principle involves requires a number of contributing features such as information technology, the commitment of public officials, the consciousness of citizens, efficient public services, proper control, etc. Consequently, the main challenge for any modern and democratic public administration is how to establish a government which is transparent and functional. Because from the modern public administration, citizens anticipate that public officials are on duty to best serve the interests of the public as well as to manage public resources with premeditated decision. Also, modern public administration should inspire citizens' trust as a fundamental instrument for good governance. The value of transparency and accountability in public administration in the last three decades received essential attention, in particular when it comes to the need for governmental reforms vis-à-vis development of societies and requests for more transparency and accountability from public officials. Thus, reformed governance should involve standards for cooperation between administration and citizens in order to promote further rule of law, citizens' participation, accountability, and transparency. The energy to construct an open and transparent administration should be generated from politicians, ministers and other high and middle public officials, civil society and citizens, if a country aims to build a modern public administration and democratic governance. Though, accountability and transparency are essential for both, democratic governance and public administration that serves its citizens. Transparency and accountability inter alia smooth the assessment of the quality of the administrative decision-making process, at the meantime, administrative practice vis-à-vis administrative justice is better harmonized with both domestic and international legal framework. Also, transparency and accountability improve the performance of public administration, as responsibility and transparency must be a push factor towards the improvement of performance. Therefore, constitutional modern democracies should not only guarantee clear rules for access to executive power, but must also ensure the transparent operation of public functions, so that society may know and evaluate governmental management and the performance of civil servants.

4.6. Recommendations

In order to ensure that the proposed inter-sectorial structural changes are effective, the following recommendations should be considered;

i) innovate and pioneer new services and programmes, which, if successful, could be replicated on a wider scale.
ii) identify local needs.
iii) respond speedily, appropriately and flexibly to local needs.

iv) promote grass-roots participation in decision-making and direct service delivery.

v) represent their particular constituencies on structures, such as policy-making and coordinating programmes, at all levels of Government to ensure that interventions are appropriate.

vi) mobilize communities to take action to meet their needs.

vii) co-ordinate action at the local level.

Chapter 5

Services and legislations related to social welfare in South Africa:

Discussion

5.1. Introduction

In a country such as South Africa, an Act informs everyday life in a wide variety of ways and is reflected in numerous forms of law. For example, an Act provides guidelines on processes to follow before a law is passed; it also regulates how implementation of legislation has to be done, thereby giving authority and value to departments. In south Africa there are numerous acts which deals with a specific sector and the existence of this acts are designed to the purposes of development the lives of the citizens while protecting them at the same time.

The purpose of this chapter is to give brief functions of the different kinds of acts in South Africa; a special attention will be given to acts that deal with social works aspects for purposes of understanding them in the context of wellness counseling.

5.2. definition of Act

An ACT is legislation passed by the Parliament. Acts can only be amended by another Act of Parliament. Acts set out the broad legal/policy principles. Acts of Parliament are formal documents which may seem difficult to understand, but you do not have to be a lawyer to understand how they work. Acts contain set elements and generally follow an established form. Acts of Parliament often give the executive, on the advice of the Cabinet and members of parliament, the right to make rules, regulations, by-laws and ordinances under a particular Act. These are called legislation and bills which must be consistent with the terms of the Act but they are not in the Act itself.

5.3. How Acts are made in South Africa?

In the Republic of South Africa; State Law Advisors certify a Bill as being consistent with the Constitution and properly drafted. The Bill then goes to national assembly for debate by members of parliament. If the Bill passes through both the NA and the NCOP after lengthy deliberations, it then goes to the President for assent (signed into law). Once it is signed by the President, it becomes an Act of Parliament and a law of the land. The diagram below shows how a law or act is created in South Africa.

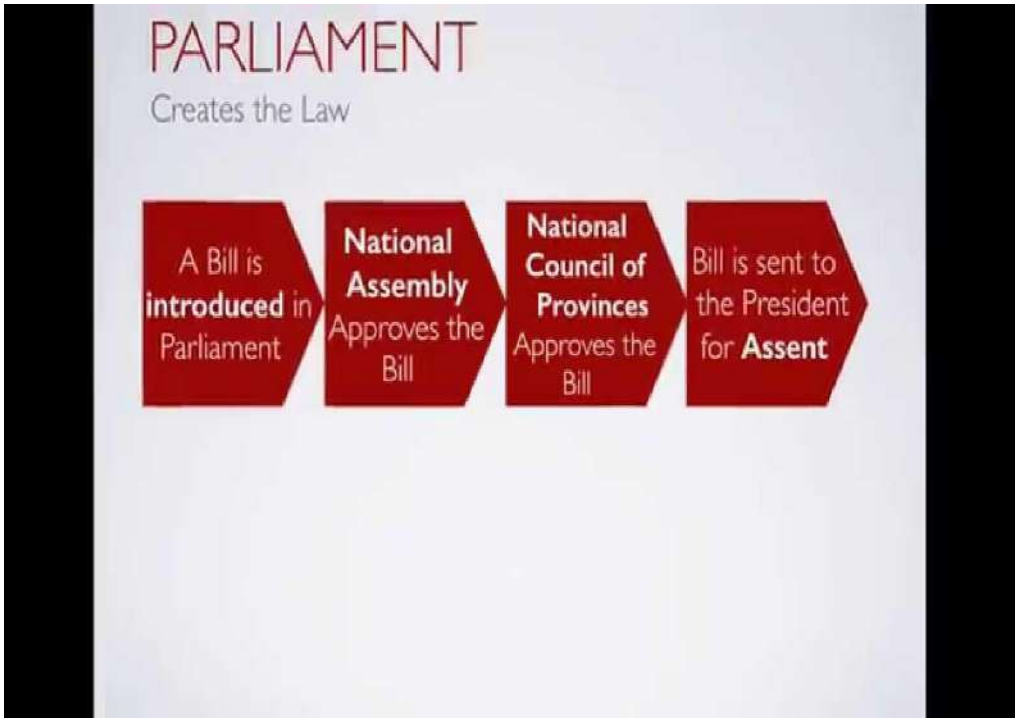


Figure 5.1 Bill/Acts process in south Africa

5.4. Services and legislation acts

5.4.1. National welfare Act, 1978 (act 100 of 1978)

The Act provides for the registration of welfare organisations on regional bases, the establishment, functions, and operations of regional welfare boards, and the establishment of a National Welfare Board.

It was amended in 06 Oct 2009 — To provide for the establishment and constitution of a South African Welfare Council and of regional welfare boards and certain committees; and to define their powers and functions; to provide for welfare programmes and for the registration of welfare organizations; and to provide for incidental matters.

This Act, formerly known as the Social Work Act, provides for the establishment of the South Africa Council for Social Work and defines its powers and functions. The Act was amended on a number of occasions – in 1995 it provided for the establishment of the South African Interim Council for Social Work and for the rationalization of certain laws relating to social workers that remained in force in the various areas of the national territory of the Republic. The Act was also amended in 1996 in order to make the South African Interim Council for Social Work more representative of the people of the country. The 1998 amendment established the South African Council for Social Service Professions and professional boards for social service professions. This Act which intends to replace the Aged Persons Act, 1967 represents a new development approach to ageing and will maintain and

promote the status of older persons, the rights of older persons as recipients of services and the well-being, safety and security of older persons. It also provides for the establishment and appointment of an Ombudsperson for Older Persons and nine provincial ombudspersons.

This particular act is relevant to social wellness in that since this act was designed to register organizations and to define their powers and functions, one could not be blamed for criticizing it for the delay of the registration of the traditional health practitioners act 22 of 2007 which has been overlooked since its inception. It is evident that there is no cohesion between this this act and the one stated above.

5.4.2. **Fund-raising Act, 1978 (107 of 1978**)

The Fund-raising Act 107 of 1978 intends:

- To provide for control of the collection of contributions from the public;
- The appointment of a Director of Fund-raising;
- The establishment of a Disaster Relief Fund, a South African Defense Force Fund and a Refugee Relief Fund;
- The declaration of certain disastrous events as disasters; and other matters connected therewith.

Commencement

1 September 1979 (Gazette 6631 of 24 August 1979)

Amended by Fund-Raising Amendment Act 43 of 1994

Amended by Fund-Raising Amendment Act 115 of 1991

Amended by Fund-raising Second Amendment Act 92 of 1981

Amended by Fund-raising Amendment Act 19 of 1981

Amended by Fund-raising Amendment Act 41 of 1980

The act is relevant to social work as it gives it powers to declare disasters. It is a known fact that disasters of any kind affect its community socially, physically, emotionally and financially and it goes without saying that there is a need for social workers and wellness counselors to get involved.

5.4.3. **social work Act, 1978 (Act 110 of 1978)**

The Social Service Professions Act (previously Social and Associated Workers Act) 110 of 1978 intend:

- to provide for the establishment of a Council for Social and Associated Workers and - to define its powers and functions;
- for the registration of social and associated workers;
- for control over the profession of social work and associated professions; and
- For incidental matters.

Commencement

1 September 1979 (Gazette 6631 of 24 August 1979)

Amendments

Amended by Social Work Amendment Act 102 of 1998

Amended by Welfare Laws Amendment Act 106 of 1996

Amended by Abolition of Restrictions on the Jurisdiction of Courts Act 88 of 1996

Amended by Social Work Amendment Act 52 of 1995

Amended by Social Work Amendment Act 22 of 1993

Amended by Social Work Amendment Act 48 of 1989

Amended by Social and Associated Workers Amendment Act 68 of 1988

This act is direct responsible for the social operations. It is without a doubt that it is relevant to social work and wellness practices.

5.4.4. **child care Act, 1983 (Act 74 of 1983)**

The Act provides for the establishment of children's courts and the appointment of the Commissioner of Child Welfare for the: protection and welfare of certain children; the adoption of children; establishment of institutions for the receptions of children; the establishment of treatment centres.

This act is related to social workers because during the cause of a child adoption, social workers are involved in accessing the environment in which the child would be living in, courts takes decisions based of the recommendations of social workers. There is a gap which needs to be filled by wellness counselors during the process of integrating the adopted child with her/his new parents guardians.

5.4.5. **children's Act, 1960 (Act 33 of 1960)**

The Children's Act, 38 of 2005

The Children's Act governs the laws relating to the care, contact and the protection of children. It defines the parental responsibilities and rights. It makes provision for the establishment of Children's Courts (although the High Court is seen as the upper guardian) and the appointment of welfare (**social workers and child care experts**) officers. The Act also regulates the establishment of places of safety, orphanages and the rights of orphans and it sets out the laws for their adoption. In all cases, the guiding principle is the best interests of the child.

Whilst the participation of social workers cannot be questioned in this act, their involvement once the children are placed by the court is lacking as there are no follow up hence the pandemic abuse of children. Again, there is a need to create a platform for wellness practitioners to get involved in the early stages when the children get assimilated to new arrangement which may be stressful to both parents and children.

5.4.6. **Aged persons' Act, 1967 (Act 81 of 1967)**

To provide for the protection and welfare of certain aged and debilitated persons, for the care of their interests, for the establishment and registration of certain institutions, for the accommodation and care of such persons in such institutions, for the payment of old age pensions and certain allowances to or in respect of certain aged persons, and for matters incidental thereto.

Aged people are the most vulnerable people in our society; they need some care as they most often become a burden to their relatives. Most aged people are stressful in their old aged homes, they require love, care, counseling a good nutrition. Ethno-medical practitioners are needed in advising of the right herbs, food and supplements that are required. Wellness counselors can also play a vital role in assisting the psychological part.

5.4.7. **Probation Services Act, 1991, (116 of 1991)**

To provide for the establishment and implementation of programs aimed at the combating of crime**; for the rendering of assistance to and treatment** of certain persons involved in crime; and for matters connected therewith. (Afrikaans text signed by the State President.)

People who were involved in crimes do not only affect their victims, their relatives, the society and the perpetrators also get affected by their crime. Often the process of healing ignored in terms of rendering the counseling to the affected. This gap can be

filled by wellness counselors as these are the people that are closer to communities as live with them.

5.4.8. **Prevention and treatment of drug dependency Act, 1992 (Act 20 of 1992)**

To provide for the establishment of a Drug Advisory Board; the establishment of programs for the prevention and treatment of drug dependency; the establishment of treatment centres and hostels; the registration of institutions as treatment centres and hostels; the committal of certain persons to and their detention.

Drug dependency is one major people problem to our society today; not only illegal substances but also legal drugs are having disastrous side effects to our people. There is little if nothing at this entire act is helping our society presently. Unless our govern assist in the advancement of natural medicine as a preventative major for drugs abuse, this problem will remain the same for a long time whilst our people are suffering. A holistic approach is recommended as a remedy to situation.

5.4.9. **Social Assistance Act, 1992 (Act 59 of 1992)**

Social Assistance Act [No. 13 of 2004;

To provide for the rendering of social assistance to persons; to provide for the **mechanism** for the rendering of such assistance; to provide for the establishment of an inspectorate for social assistance; and to provide for matters connected therewith. Jun 10, 2004, was repealed when the Child Care Act (Act 96 of 1996) comes into operation and Child Care Amendment Act (Act 96 of 1996)

To amend the Child Care Act, 1983, so as to amend, insert or delete certain definitions; to provide for legal representation for children; to shift the focus from the unable or unfit parent to the child in need of care; to further regulate the provisions relating to the adoption of children, Jan 1, 1996.

5.5. ACTS PROMULGATED BY THE FORMER INDEPENDENT STATES

The acts under this category were primarily established to cater for the needs of the various former independent states. Most of the objectives of these acts are already covered by the establishment of new acts post democracy. Whilst most of these acts are related to social welfare of the people; most of them are a duplicate in new South Africa, hence the relevance of them is covered under the discussions of the new acts. Their relevance discussions in social work are therefore unnecessary.

5.5.1. **Lebowa Social Pensions Act, 1978 (Act 11 of 1978)**

- Welfare Laws Amendment Bill [B90B-97;

Mar 30, 2009 - the practicing of such a specialist under the Social Work Act, 1978 (Act 110 ... 11 Removal of child to place of safety on order of court or on sworn ... (b) Notice of the conclusion of any such agreement, and a summary of the provisions ... Pension Laws Amendment Act, 1962 ... (Lebowa) Children's Act, 1960.

5.5.2. **Ciskeian Social Pensions Act, 35 of 1976**

- Pension Laws Amendment Act

In Aug 27, 2019 the Pensions Laws Amendment Act was passed by the parliament in 1944 disrupt the social structure and cause urbanization and detribalization, above all , Petition Proceedings Replacement Act, 1976 (Act 35 of 1976) assistance to accused persons.

5.5.3. **Venda Social Pensions Act 69, 1996**

- Special Pensions Act 69 of 1996

Dabalorivhuwa Patriotic Front vs. Republic Of South Africa.

The Venda people are from Venda (presently part of South Africa), which had the status of a self-governing state as at 1979. It is alleged that the Venda Government, passed the Venda Government Service Pension Act 4 of 1979, dealing with retirement benefits for male and female employees.

5.5.4. **Gazankulu Social Pensions Act, 1976 (Act 7 of 1976)**

- Welfare Laws Amendment Act [No. 106 of 1997.

exemption to certain categories of persons who may care for certain children apart from their parents for a period longer than 14 days; and to remove the provisions that overlap with the provisions of the Social Assistance Act, 1992, that provide for state contributions to the maintenance by foster parents of foster ...Dec 19, 1997

5.5.5. **Children’s Act, 1985 (Ciskei) (Act 18 of 1985)**

To amend the Child Care Act, 1983, so as to broaden the provisions granting exemption to certain categories of persons who may care for certain children apart from their parents for a period, 18 of 1985 (Ciskei).

5.5.6. **National Welfare Act, 1987 (Ciskei) (Act 18 of 1987)**

Welfare Laws Amendment Act 106 of 1996

Dec 19, 1997, Amendment of section 10 of Act 74 of 1983, as amended by section 3 of Act 96 of. 1996. 1. Section 10 of the (i) has applied in terms of section 18 for the

adoption of the child; V e n d a, Ciskei, Gazankulu, KaNgwane, KwaNdebele, KwaZulu. Iebowa or QwaQwa, (Ciskei). National Welfare Act. 1987.

5.5.7. **Venda National Welfare Act, 1981 (Act 9 of 1981)**

Welfare Laws Amendment Bill (B90D-97)

To define an expression; to restore the administration of the Act to the national government after Amendment of section 9 of Act 59 of 1992, as amended by paragraph 3 of Part 1 of the Schedule to territory of any former entity known as Transkei, Bophuthatswana, Venda, Ciskei. National Welfare Act, 1981. Act Xo.21.

5.6. LEGISLATION PERTAINING TO WELFARE FUNCTIONS BUT ADMINISTERED BY OTHER MINISTRIES

5.6.1. **Mediation in Certain Divorce Matters Act, 1987 (Act 24 of 1987) as amended by:**

The Act means the Mediation in Certain Divorce Matters Act, 1987 (Act No. 24 of 1987), an applicant in any application for the variation, rescission or suspension of an order made in terms of the Divorce Act, 1979 (Act No 3, 2011). 121 of 1991) amended the Mediation in Certain Divorce Matters Act, 1987, to allow the appointment of a special Family Advocate to handle a particular divorce.

Whilst it must be applauded that this act seeks to ensure process of divorce is handling within the confines of the law, this act however is silent on the emotional part aspect of the parties involved. Divorce is a stressful process that requires counseling to all parties involved. It is therefore recommended that act should address also the inclusion of wellness counselors to assist parties involved during the transition period.

5.6.2. **Criminal Procedure Act, 1977 (Act 51 of 1977) as amended by:**

Act 51 of 1977 determined the tariff in the Schedule. 1. A psychiatrist who is designated or appointed by or at the request of the court or a clinical psychologist who is directed by the court in terms of section 79(1) of the Criminal Procedure Act, 1977. Correctional Services and Supervision Matters Amendment Act, 1991 (Act 122 of 1991)

Mar 14, 2019 - To amend the Correctional Services Act, 1998, so as to insert, substitutes amend or Criminal law (sexual offences and related matters) amendment act. Further abolition of racially based measures bill 117 1991 ... Game theft bill 122 1991 ... Parole and correctional supervision amendment bill 57 of 1997.

5.7. RELATED LEGISLATION THAT ALSO NEEDS TO BE SCRUTINISED REGARDING ITS IMPACT ON SOCIAL FUNCTIONING AND SOCIAL WELFARE SERVICES

5.7.1. **Health Act, 1977 (Act 63 of 1977**

- National Health Act [No. 61 of 2003

To provide for measures for the promotion of the health of the inhabitants of the Republic; to that end to provide for the rendering of health services; to define the duties, powers and responsibilities of certain authorities which render health services in the Republic; to provide for the co-ordination of such health.

This act is directly related to wellness counseling, according to act 22 of 2007, traditional health practitioners should form part of the primary health care system.

5.7.2. **Mental Health Act, 1973 (Act 18 of 1973**

To provide for the reception, detention, treatment of persons who are mentally ill and to provide for incidental matters. Jun 10, 2019.

Since the treatment of people who are mentally cannot be limited to conventional medicine only, this act is related to wellness counselors if when holistic approach is incorporated in our health system.

5.7.3. **Abortion and Sterilization Act, 1975 (Act 2 of 1975**

- Choice on Termination of Pregnancy Act 92 of 1996.

To define the circumstances in which an abortion may be procured on a woman or in which a person who is incapable of consenting or incompetent to consent to sterilization, may be sterilized; and to provide for incidental matters.

Wellness counselors can refer clients who in need are in need of such services to qualified practitioners.

5.7.4. **Human Tissue Act, 1983 (Act 65 of 1983)**

Act 65 of 1983 authorize Highveld Biological (Pty) Ltd to acquire and use import frozen human seed material of established cell lines for culture in vitro and research purposes, lawfully imported or removed from the body of a living or deceased person.

5.7.5. **Children's Status Act, 1987 (Act 82 of 1987)**

- Children's Act [No. 38 of 2005]

The Act details the circumstances when a person is presumed to be the father of an extramarital child unless proved otherwise. The status of any child born of a voidable marriage is not affected if the marriage if voided. No such marriage will be voided, however, until the interests of any children are safeguarded.

Most of the time children who affected by such situations are the most vulnerable ones in our society. When a wellness counselor encounters such a situation, he/she can refer them to act.

5.7.6. **Prevention of Family Violence Act, 1993 (Act 133 of 1993)**

To provide for the granting of protection orders with regard to domestic violence; for an obligation to report cases of suspected ill-treatment of children.

Wellness counselors can assist in bringing awareness to children who are exposed to abuse and also give advice on this act.

5.7.7. **Sexual Offences Act, 1957 (Act 23 of 1957)**

The Sexual Offences Act (previously Immorality Act) 23 of 1957 aims: to consolidate and amend the laws relating to brothels and unlawful carnal intercourse and other acts in relation thereto.

Any form of sexual abuse lives scars to affected individuals. Quite often perpetrators of these crimes have a history of being previously exposed to some form of abuse. Proper counseling assists the perpetrators. Early signs of abuse should be attended to by professional counselors such as wellness counselors. This act is therefore related to wellness counselors in this way.

5.7.8. **Marriage Act, 1961 (Act 25 of 1961)**

The Marriage Act, 1961 (Act No. 25 of 1961) is an act of the Parliament of South Africa governing the solemnization and registration of marriages in South Africa. Some issues relating to marriage remain governed by the Roman-Dutch common law because they have never been addressed by Parliament.

Marital problems are of the most encountered problems by counselors. Wellness counselors can refer their clients to this act when a need arises.

5.7.9. **Matrimonial Property Act, 1984 (Act 88 of 1984)**

It is an extension the commencement of the Matrimonial Property Act, 1984, immovable property, real rights in immovable property and notarial deeds which would upon transfer, cession or registration thereof form part of a joint estate shall be registered in the name of the husband and the wife, excluding agricultural land as, Mar 4, 2012.

5.7.10. **Maintenance of Surviving Spouses Act, 1990 (Act 27 of 1990)**

The Maintenance of Surviving Spouses Act, 27 of 1990, was drafted to give a spouse legal recourse if disinherited or negatively affected by the wishes of the testator, or in the case of intestate succession. May 16, 2019.

5.7.11. **Matrimonial Affairs Act, 1953 (Act 37 of 1953)**

To amend the law relating to the property **rights** of spouses, to orders for maintenance, to the guardianship and custody of minors and to divorce. Oct 4, 2012.

One of the most dangerous issues of marital matters is that affected people do not know their rights as citizens. In cases where a spouse is confused, a wellness counselor may refer her/him to this act. This act is therefore relevant to wellness counseling in that sense.

5.7.12. **Divorce Act, 1979 (Act 70 of 1979)**

To amend the law relating to divorce and to provide for matters. A court may grant a decree of divorce on the ground of the irretrievable break- down of a marriage if it is satisfied that the marriage relationship between the parties to the marriage has reached such a state of disintegration that there is no reasonable prospect of the restoration of a normal marriage.

5.7.13. **Divorce Amendment Act, 1988 (Act 3 of 1988)**

- Marriage and Matrimonial Property Law Amendment Act 3 of 1988

This Act puts Black civil marriages on the same footing as those of the rest of the population of South Africa. The Act also forbids a Black man and woman from marrying according to a civil ceremony, if the man is involved in a customary union with another woman.

5.7.14. **Maintenance Act, 1963 (Act 23 1963)**

- Maintenance Act [No. 99 of 1998]

To restate and amend certain laws relating to maintenance.

The Minister of Justice has, under section 44 of the Maintenance Act, 1998 (Act No 23. recovery of arrear maintenance. The clerk of the court shall submit a certified 80 of 1963) and the Reciprocal Enforcement of Maintenance Order.

5.7.15. Reciprocal Enforcement of Maintenance Orders Act, 1963 (Act 80 of 1963)

The Reciprocal Enforcement of Maintenance Orders Act 80 of 1963 intends: to consolidate and amend the laws relating to the reciprocal enforcement of maintenance orders made in the Republic and proclaimed countries, and. to provide for other incidental matters.

5.7.16. Births and Deaths Registration Act, 1992 (Act 51 of 1992)

To regulate the registration of births and deaths; and to provide for matters connected therewith.

5.7.17. Age of Majority Act, 1972 (Act 57 of 1972)

29 Section 1 of the Age of Majority Act 57 of 1972 reads as follows: All persons, whether males or females, attain the age of majority when they attain the age of twenty-one years.

5.7.18. Legal Aid Act, 1969 (Act 22 of 1969)

- Legal Aid Amendment Act, 1991 (Act 1 of 1991)

The objective of the Legal Aid South Africa is to

(a) render or make available legal aid and legal advice;

(b) provide legal representation to persons at state expense; and

(c) **Provide education** and information concerning legal rights and obligations, as envisaged in the Constitution and this Act.

The provision of education as prescribed the act is not occurring in reality. That is a lot of people in our society lack knowledge with regarding the benefits of this act. Wellness counselors can be included as part of the training process as they are directly involved with the matters that relates to this.

5.7.19. Law of Evidence Amendment Act, 1988 (Act 45 of 1988)

To amend the law of evidence so as to provide for the taking of judicial notice of the law of a foreign state and of indigenous law; and to lay down general requirements for the admissibility of hearsay evidence; to amend the Civil Proceedings Evidence Act, 1965, so as to regulate further at civil proceedings .Mar 4, 2012.

5.7.20. **Occupational Diseases in Mines and Works Act, 1973 (Act 78 of 1973)**

Occupational Diseases in Mines and Works Act, 1973 to consolidate and amend the law relating to the payment of compensation in respect of certain diseases contracted by persons employed in mines and work and matters incidental thereto.

Occupational diseases occur as result of workers exposed to harmful environment in their workplace, such diseases in most cases creates a permanent damage to people affected. Holistic practitioners can play a major role in educating, training designing preventative majors in this sector.

5.7.21. **Unemployment Insurance Act, 1966 (Act 30 of 1966)**

- Unemployment Insurance Act [No. 63 of 2001]

The purpose of this Act is to establish an unemployment insurance fund to which employers and employees contribute and from which employees who become unemployed or their beneficiaries, as the case may be, are entitled to benefits and in so doing to alleviate the harmful economic and social effects of unemployment.

5.7.22. **Workmen’s Compensation Act, 1941 (Act 30 of 1941)**

The Compensation Fund provides compensation for workers who get hurt at work, or sick from diseases contracted at work, or for death as a result of these injuries or diseases. Workers injured before 1 March 1994 are covered by the old Workmen's Compensation Act. This section deals with the new COIDA only.

5.7.23. **Compensation for Occupational Injuries and Diseases Act, 1993 (Act 130 of 1993)**

The Compensation for Occupational Injuries and Diseases Act, No 130 of 1993 (COIDA) provides for compensation for disablement caused by occupational injuries or diseases sustained or contracted by employees in the course of their employment, or for death resulting from such injuries or diseases.

5.7.24. **Basic Conditions of Employment Act, 1983 (Act 3 of 1983)**

- Basic Conditions of Employment Act [No. 75 of 1997]

South African immigration legislation stipulates that foreign workers must be remunerated and employed fairly. The Basic Conditions of Employment Act is the yardstick against which this is measured. This document stipulates the conditions under which employees, both South African and foreign, must be employed.

5.7.25. **Friendly Societies Act, 1956 (Act 25 of 1956)**

The Friendly Societies Act 25 of 1956 aims: to provide for the registration, incorporation, regulation and dissolution of friendly societies and for matters incidental thereto.

5.7.26. **Prisons Amendment Act, 1990 (Act 92 of 1990)**

To amend the Correctional Services Act, 1959, so as to regulate the transformation of the Department of Correctional Services into a non-military institution and, for that purpose, to delete certain definitions and to replace or insert certain others; to abolish the Correctional Services Reserve Force; to make further provision for the early retirement of correctional officials; to make further provision regarding canteens at prisons; and to delete the provisions in respect of infliction of corporal punishment and detention of judgment debtors; and to provide for matters in connection therewith.

5.7.27. **Drugs and Drug Trafficking Act, 1992 (Act 140 of 1992**)

To provide the prohibition of the use or possession of, or the dealing with drugs and of revision of acts relating to the manufacture or supply of certain substance.

5.7.28. **Gambling Act, 1965 (Act 51 of 1965)**

- Gambling Amendment Act, 1988

To provide for the co-ordination of concurrent national and provincial legislative competence over matters relating to casinos, racing, gambling and wagering, and to provide for the continued regulation of those matters; for that purpose to establish certain uniform norms and standards applicable to national and

5.7.29. **Lotteries and Gambling Board Act, 1993 (Act 210 of 1993)**

- National Gambling Act 2004 (No. 7 of 2004)

To provide for the establishment of a board with a view to the implementation of lottery, gambling and fund-raising activities; and to provide for matters connected therewith. (Afrikaans text signed by the State President.) (Assented to 14 January 1994.)

5.7.30. **The traditional health practitioners act 22 of 2007.**

- To provide the management and control over the registration, training and conduct of practitioner's students and specified categories in the traditional health profession, and to provide for matters connected therewith.

This act is directly related to wellness counselors, ethno-medical practitioners, traditional health training and yet there is little movement with regard to implementation of this act.

5.7.31. **National Health Insurance Bill B11-2019.**

Achieve the progressive realization of the right of access to quality personal healthcare services;

● make progress towards achieving Universal Health Coverage;

● ensure financial protection from the costs of health care and provide access to quality health care services by pooling public revenue in order to actively and strategically purchase health care services based on the principles of universality and social solidarity;

● create a single framework throughout the Republic for the public funding and public purchasing of health care services, medicines, health goods and health related products, and to eliminate the fragmentation of health care funding in the Republic;

● promote sustainable, equitable, appropriate, efficient and effective public funding for the purchasing of health care services and the procurement of medicines, health goods and health related products from service providers within the context of the national health system; and

● ensure continuity and portability of financing and services throughout the Republic.

The establishment of this act was a step to the right direction in many ways as it seeks to holistically deal with the health care system of the country holistically. This act however lacks practical details with regard to the incorporation of alternative medicine in the health care system. One would have thought that one of tools to

advance the objective of this act would be the promotion of the traditional health sector which is not given priority by the state.

5.7.32. **The Protection of Personal Information Act (POPIA) is South Africa's data protection law.**

-the purpose of the Protection of Personal Information Act (POPIA) is to protect people from harm by protecting their personal information. To stop their money being stolen, to stop their identity being stolen, and generally to protect their privacy, which is a fundamental human right.

To achieve this, the Protection of Personal Information Act sets conditions for when it is lawful for someone to process someone else's personal information.

Conclusion

It is clear from the above that most of the bills are related to wellness counseling as most of them are dealing with the social lives of the society. It also evident that even though the 8acts are well crafted; there is lack of implementation from national to local level. Whilst there seems to be lots of acts are dealing with the social welfare of the society there are still some improvements that need to occur, such as the promotion of wellness counseling to be incorporated in the primary health care.

Recommendations

In order for government to close gaps on the various acts and make it a reality to the society needs, the following recommendations must be considered;

- Government need to enhance continuous campaigns and trainings.
- Government need to promote citizens participation to social health related matters.
- Create implantable deliverable programs.
- Promote partnerships with NGO and private health practitioners.

5.8. How wellness counselling can be expanded to include wider social services?

5.8.1. **Introduction**

The South African social welfare system is characterized by the need for the transformation of services and the need for the promotion of service integration among different stakeholders. In the context of the wellness counseling, transformative processes brought by

political reforms that were previously introduced should be improved. It is also clear that there is lack of national participation as a result of government to create inclusive guidelines to its policies. This has resulted in non-societal participation from the marginalized who perceived to be excluded in the planning and implementation processes. The lack of society trust against government as the result of rampant corruption has also caused a mistrust between government and the society. It is also clear that government is now failing to address societal issues by lacking to promote partnership between stakeholders; wellness counseling, religious leaders, local government, social welfare and other government departments.

The purpose of this assignment is to discuss the role of wellness in the social services industry and how it can be extended to wider social services roles to qualify for subsidies.

5.8.2. The need for an integrative holistic approach to Social Work

South Africa has previously had welfare functions which were combined with health and/or were split across various other government departments. This led to fragmentation of the welfare function and a lack of acknowledgement by government of the role of social welfare services in promoting social development. At present, responsibility for social welfare is located in the national and provincial departments of welfare in terms of the constitution of the Republic of South Africa. Social welfare is not a function of local government according to the constitution, but welfare services have, to a limited extent, also been rendered by local authorities under the former government. Approximately 110 social workers are employed nationally by the former black local authorities and other local authorities. Other government departments are partners in service delivery, such as the departments of correctional services, health, justice, education, labour, public works, housing and sport and recreation. In addition, departments such as the South African national defence force (SANDF) and the South African Police Services (SAPS) render social services to their employees. There are also Government departments which provide financing for community-based organisations (CBOs) whose functions are closely aligned with those of the department of welfare. Duplication and fragmentation both within and between Government departments is due to confusion about roles and responsibilities. Mechanisms for collaborative policy development, planning and funding are either lacking or inadequate. The role of civil society in this is unbearable. The welfare sector has a large institutional infrastructure rooted in civil society. A rich tradition of involvement on the part of civil society and an organisational resource base have been built up over decades. No accurate statistics are available of the numbers of non-governmental organisations (NGOs) which currently deliver social services and development programmes. It is estimated that there are up to 10 000 organisations in civil society which have a welfare and development focus. They are based either in the formal welfare sector (that is, welfare organisations which are government-subsidised and religious organisations delivering welfare services, some of which are government-subsidised), or in what is popularly referred to as the informal welfare sector (organisations which are currently not government-subsidised). Informal social networks exist which provide tangible and intangible resources and social support. These consist of networks such as family, friends, neighbors and indigenous helping systems e.g. self-help groups, and spiritual and customary networks. The Wellness counselling sector plays a pivotal role as civic contributor to community wellbeing in general and counselling needs in particular. It also follows a holistic approach that sees mental, emotional and social wellbeing as integrated aspects of human

existence. This means that health is not the absence of disease, but a positive state of complete wellbeing and moreover, any one aspect of wellness affect all other aspects. Hence, a wellness enhancement counselling protocol requires a comprehensive approach to healthcare in line with social wellbeing. The goal of wellness is to foster development that would enable people to participate in the 'good life' which is exactly the purpose of social and welfare intervention. There are approximately 4 800 organisations which are registered in terms of the Fundraising Act, 1978, and of this total, approximately 50% are registered as welfare organisations in terms of the National Welfare Act, 1978. Further, the majority of registered welfare organisations are government-subsidised though they raise substantial proportions of their budgets themselves. Welfare organisations provide direct social services for particular target groups such as children and families, family life services, services in regard to problems related to substance abuse and mental health, and services to offenders and their families. This sector has a developed infrastructure, skills and resources, which have evolved over many years. Most welfare organisations are affiliated to the 26 national councils, which are constituted on the basis of their specialized fields of service, their religious orientation, the social relief and development they may offer, or the fact that they are women's organisations. Roughly half of the national councils' operating budget is financed by Government and the rest is raised through fund-raising programmes.

 Co-ordination of services; representation of affiliates on national and provincial structures; human resource development; marketing and public education; professional support services and organisational development; fundraising; development of new services; and policy and programme development.

 Extensive social services, facilities and development programmes are also rendered by some religious communities. About 40% of welfare services delivered by religious organisations are registered as welfare organisations. Religious welfare organisations also receive Government subsidies for some of their programmes. There are no accurate statistics of the number of religious organisations rendering welfare services and how much they contribute financially to social welfare. This contribution is however considered to be substantial.

 The majority of services are residential and non-residential services such as homes for the aged, children's homes, care of the terminally ill, homes for unmarried mothers, churches, and special schools for the handicapped and the destitute. Other programmes which are offered include social relief and development; reconciliation and justice; counselling; and alcohol and drug services.

5.8.3. **The informal welfare sectors**

A substantial informal welfare sector has developed in South Africa, with its roots in the anti-apartheid movement. These organisations pioneered people-centered development strategies, identified gaps in the delivery system which they attempted to fill, and lobbied for policies to effect fundamental social, economic and political changes. These NGOs are funded almost exclusively by foreign donors; their future is uncertain as new partnerships and funding policies develop. They are involved in direct service delivery and development programmes in various areas of social welfare. The Department of Welfare is moving towards the equal treatment of NGOs in the formal and informal welfare sectors.

5.8.4. **Occupational social welfare**

Occupational social welfare and other social service programmes are provided by various businesses for their employees and their families. Business and corporate social investment programmes also fund social welfare and social development programmes in local communities and nationally. They contribute to capacity building for welfare and development programmes through training in management, administration, finance and budgeting. Social workers are employed in commerce and industry and are involved in the delivery of social services to employees and their families. These services are part of other services offered in the workplace such as employee assistance programmes and medical services. Although the business sector funds social service and community programmes and has provided expertise and skills in the management of community-based programmes, there is inadequate consultation between key stakeholders on occupational social services in the workplace. More developmental interventions and services are needed in the workplace. Social work services to individuals, families, groups, communities, organisations, the business sector and Government are provided by social workers in private practice. Social workers in private practice render services to those in society who can afford to pay for the services. In addition, their services are contracted by organisations and institutions. They offer specialist knowledge and skills in different fields, flexibility and consumer choice.

5.8.5. **conclusion**

Given the diversity of stakeholders in the welfare field there is a wealth of knowledge, skills and resources which should be harnessed by the Government and its partners in a restructured welfare system. However, problems exist, which include the following: inequity, fragmentation, the duplication of services (which has resulted in inefficiency), a lack of capacity and infrastructure (which contributes to ineffectiveness in meeting needs), and inadequate intersectoral collaboration and communication. In some instances, there has been inadequate financial accountability and discipline. The organisational capacity of the different partners is uneven. Skills are also often concentrated in certain fields. Rural areas and disadvantaged urban communities are underserviced. Differences in approach, philosophies, styles of work, methods and traditions, experience in working with developing communities, and the social, economic and political context within which organisations in civil society have evolved, have contributed to diversity in the welfare sector. Competition for scarce resources and areas of service delivery, and the fact that some organisations were subsidised while others were denied the right to freedom of association and expression, have contributed to tensions between NGOs.

5.8.6. **What kind of participation can wellness provide in wellness structures?**

One of the challenges of the South African government was that it previous failed to include all relevant stakeholders to participate in social services. It is encouraging to learn that government has developed a road map plan to enhance the social welfare sector. This essay will identify areas where wellness counsellors can participate in the various governance and how can they contribute in the planning process.

Government has undertaken to facilitate the development of an inclusive and effective partnership with all the role players in civil society. The resources and the unique

characteristics of each of the partners will be harnessed to maximum effect. Underpinning the partnership is the recognition of the role of organizations in civil society as essentially developmental and as strengthening democracy.

Government has also stated that a genuine partnership will have a common purpose but will also provide for advocacy. Such a partnership will be structurally efficient, effective and responsive to local needs. The relationship between the parties will be based on a mutual commitment to meeting basic material, social and psycho-social needs, while acting in the public interest.

According to government, the partnership will be complementary; it will leave room for the autonomy of the parties, for joint decision-making, for joint responsibility, representation and a commitment to excellence. Decisions will be taken democratically and mechanisms will be introduced for the arbitration of disputes. The restructuring of the partnership between Government and civil society will be based on agreed goals, principles, strategies and priorities. The roles and responsibilities of each of the partners will be defined and negotiated where necessary. Where there is duplication, organizations will be encouraged to rationalize their services and structures as a means to overcoming fragmentation in the delivery system. Effective and appropriate mechanisms will be developed to facilitate the following: participation and consultation in policy development, planning and the evaluation of social programs; intersectoral collaboration; the development of criteria for the financing of programs and services; and the development of appropriate regulations, norms and standards.

An integrated institutional framework for the delivery of developmental welfare programs will be developed in consultation with all stakeholders in Government and in civil society. Government will address needs which are not being met by its partners in civil society. In this regard, Government will also play an enabling and pro-active role to ensure that services are provided in under-serviced areas. Government will provide an enabling environment for the delivery of developmental welfare services by its partners.

Organizations in civil society will be responsible for direct service delivery, advocacy, information systems, accountability and participation. There will be co-operation in operational research. A national information system and early warning systems will be developed.

Organizations in civil society are particularly well placed to; innovate and pioneer new services and programs, which, if successful, could be replicated on a wider scale; identify local needs; respond speedily, appropriately and flexibly to local needs; promote grass-roots participation in decision-making and direct service delivery; represent their particular constituencies on structures, such as policy-making and coordinating programmes, at all levels of Government to ensure that interventions are appropriate; mobilize communities to take action to meet their needs; co-ordinate action at the local level; take advantage of economies of scale; and monitor strategies aimed at achieving equity.

The informal welfare sector that is rendering social services and developmental programmes which were previously not formally integrated into the welfare system, will be accorded equal status with other organizations in civil society. Organizations in this sector will have the same benefits and responsibilities as their counterparts in the formal welfare sector regarding accountability and adherence to minimum standards.

A representative structure made up of government and civil society will be established immediately to address the reorientation, rationalisation and restructuring of the formal welfare sector including national councils, in accordance with the goals, principles and

actions identified previously. The terms of reference of the task group will be defined in consultation with the role players.

5.8.6.1. **Governance**

It is encouraging that government has stated that Appropriate, legitimate, transparent and effective governance mechanisms will be developed at local, district, provincial and national levels to build and consolidate the partnership between Government and all stakeholders in civil society. A plan to develop such mechanisms will be negotiated with all role players. The aims of governance structures will be top;

(a) undergird policy development and planning.

(b) assist in the development of legislation.

(c) co-ordinate the delivery of services.

(d) facilitate the exchange of information.

(e) determine and monitor the Reconstruction and Development Program goals

and priorities.

(f) assist in developing criteria for social programs and their funding.

(g) facilitate and build an effective delivery system.

5.8.6.2. **Interim governance structures**

It will advisable for the proposed Interim structure to work in partnership with other organizations such as the interim body of traditional health practitioners in order to ensure that a holistic approach to social welfare is integrated to governance mechanisms to meet the above aims and this must be established as soon as possible. These mechanisms must involve government and civil society, and should operate at national and provincial levels. Such structures should not, however, duplicate existing consultative processes, and will be based on the needs of the current transition. These mechanisms will be evaluated and adjusted, and will also form the basis for the establishment of more permanent statutory mechanisms. Representation on such interim structures will be broad and inclusive but will not be such as to make the structures unwieldy. Time frames and terms of reference will be clearly defined. To facilitate networking between stakeholders, appropriate structures, networks and task groups will be established to promote participation at local level. In this way, all stakeholders will be given the opportunity to participate in the development of effective governance structures at all levels.

5.8.6.3. **Representation**

It is also encouraging that organizations in civil society delivering social services and development programs will ensure that the decision-making structures of the organizations are representative of consumers of services, members of the communities being served and other relevant role players. These structures may differ from community to community and from province to province according to the specific needs of the people, and the available resources.

Opportunities will be created to ensure the appropriate participation of the consumers of services so that the services are responsive to their needs. Guidelines to promote the appropriate participation and involvement of consumers will be developed. Capacity building will be considered where they are needed.

5.8.6.4. **Ombudsman**

Government has also stated that in order to ensure an effective and efficient service delivery system, the offices of ombudsmen will be established in the national and provincial welfare departments. The roles, responsibilities, functions and powers of ombudsmen will be clearly defined. This is also encouraging news that needs to be welcomed by the larger society because for quite a long-time community participation has been overlooked and other organizations such churches have been ignored yet they play a major role in uplifting the loves the of the society.

5.8.6.5. **conclusion**

The proposed changes by our government is encouraging, one must applaud the direction our government is taking, the challenge will on implementing, as it is known that our country has got the best systems in the world but short fall in applying and implementing them. The inclusion of civil society groupings, partnering with relevant stakeholders, society representation and the proposed setting up of an ombudsman are steps to the right direction.

5.9. The contribution of wellness to aspects of social work: Therapeutic and restorative work to social needs.

5.9.1. **Introduction**

Social workers are employed by the social welfare sector, part of the duties is to support individuals and their families through difficult times and ensure that vulnerable people, including children and adults, are safeguarded from harm. Their role is to help improve outcomes in people's lives.

Social workers also maintain professional relationships and act as guides and advocates. They sometimes need to use their professional adjudicative skills to judge on matters of social welfare such as in the family court where disputes of children’s parental cases are decided.in some of this cases, they require reports of psychologist to ensure that they arrive at the right decisions as this may be outside their scope of practice. The fact that they have rely on external sectors to get involve some instances, shows that their scope of practice has not been designed in a holistic manner. This essay will discuss the role wellness counsellors can play in the aspects of therapeutic, restorative and social development.

5.9.2. **Therapeutic needs**

Wellness counsellors in their scope practice seek address the whole person (well-being) this involves holistic therapy, or holistic psychotherapy, which a subject of a school of thought in therapy that attempts to address an individual as a whole person rather than as someone who is sick, just has psychological issues, or as being separated into different

components. Holistic therapy attempts to address the individual in terms of their mind, spirit, and body. Wellness counsellors are well equipped in contributing to society to contribute to social work with kind of skills.

The notion of wellness counselling assumes that a person's self-perception or their consciousness is not to be found in any one particular area but is an integration of the entire person, including their physical body, mind as a function of the brain, feelings or emotions as a function of the interaction between the brain which contains the central nervous system and the physical body, and spirit which is the higher part of oneself that connects one to others and to an understanding of meaning. Wellness counselling seeks to have the individual gain awareness of these connections between the mind, body, and spirit using a number of different techniques. The goal is to help individuals to develop a much deeper understanding of themselves at all levels, which can often lead to improved self-esteem and self-awareness.

A therapeutic approach delivered by social workers reduces levels of trauma among victims in the society who have experienced sexual abuse, victims of domestic violence, drug addicts and so on. This is clearly outside the current framework of the social development guidelines.

Wellness counsellor's approach is to balance all the different aspects of the person as stated earlier, so the entire person is addressed in treatment and not just one aspect of the person. For instance, an individual may develop depression as a result of divorce conflicts which may require more than emotional counselling but also needs to be advised on what medicinal assistance can the take to assist them in healing the stress or depression.

5.9.3. **Restorative needs**

Restorative practice defined as a positive discipline, or empowerment, it is a strategy that seeks to repair any harm done to people, and relationships that have been damaged. Rather than simply punishing an offender, it aims to make them take responsibility for their actions, be aware of the consequences they have caused, and feel remorseful.

Our justice system has adopted this aspect where victims meets with their perpetrators and the perpetrators are given a chance to offer an apology to the victims. This is done with the understanding that both parties are affected in one way or the other and for the purposes of closure, and reconciliation. This is done through meetings with people who have been affected by their actions, who explain the impact that they have had. From the victim's perspective, these meetings can help them to forgive, move on, and reconcile with the offender.

The objective of this process is not on punishment, because punishment is often not enough to deter people from crime or misbehavior if it was, these things would not be so prevalent. People also need to learn about the responsibility that they have had in a situation, how it affected other people, and how they can put it right. This kind of process required more than a social worker; it requires a certain level of taring which the moment is beyond the social work scope hence there is a need for wellness counsellors to feel this gap.

It has been found that the restorative approach is extremely effective. Its aim to work with people, rather than doing things *to* or *for* them, leads to them feeling heard and involved. As a result, they are more likely to make positive changes in their behavior. This leads to a reduced likelihood of reoffending, and thus a decrease in crime, violence, and bullying.

This positive approach must be adopted in many different fields. These include criminal justice, organizational leadership, social work, counselling, youth services, and education. For restorative approach to be successful, he following principles must be applied;

i) **Relationships must be central to building a community**

In order to have a good community, the society need to sustain positive relationships. This means repairing any harm that has been done, and ensuring that it does not occur again in the future.

ii) **Everyone's voices must be heard and valued**

Human relationships are healthiest when we express our emotions freely, which reduces the intensity of feelings hence there is a need to have a platform for a free dialogue to occur on matters that affected an offender and a victim. In other words, a person should be separated from their behavior. Doing so acknowledges that the 'offender' may have unmet needs, and these needs are the reason behind their behavior. Listening and solving the problem ensures that the incident does not reoccur. It also leaves the 'offender' with self-respect, dignity, and a sense of belonging in the community.

iii) **To minimize misbehavior and crime, by repairing the harm caused, not punishing people for breaking rules**

Repairing harm and relationships prevents future harm, as well as restoring trust and strengthening the community.

iv) **Problem-solving must be collaborative**

To make the whole community feel involved and positively motivated, let them all participate. Everyone should discuss the problematic situation that has arisen, and decide on a fair solution. Thinking through the event including what was right or wrong, and how it could have been handled differently teaches the 'offender' what they should do in future. Consequences that you decide on should be based on the unmet needs of both 'offender' and 'victim'. They should be reasonable, respectful, and related to the offence.

V) **Accountability and responsibility lead to change and growth**

Learning and understanding the impact of his/her actions, determining how to fix them, and actually following through with this plan leads to positive self-growth. This process makes the offender feel remorseful, which reduces the likelihood of reoffending. These principles must be applied in practice using different restorative approaches with the participation of wellness counsellors

5.9.4. **Social development needs**

One of the common complaints amongst social workers that they do not have the time or the skills to do counselling. On the other hand, there are some who believe that they are counselling in most or all of their work. Others in social work asserts that counselling is largely irrelevant to the resolution of problems presented by most social work clients, since these are primarily the product of structural, material or environmental factors. Moreover, proponents of counselling sometimes think that it has been confined to specialist settings by current emphases and philosophies, such as community social work, genericism, managerialism. and child protection. By the looks of things there is no current consensus either about what it is meant by `counselling' or about what part it should play in social work. The term 'counselling' has largely been referred to professionals who are not included in the social work sector. These are often practitioners.

Social workers often not skilled for counselling hence most of the time they focused more on the social aspects of the society. Indeed, others may have a greater claim to expertise. The label is used by psychologists, psychiatrists, nurses, therapists, clergy, lay people, trained volunteers and others. If asked to give an example of a counsellor, members of the public might well be more likely to talk of marriage guidance counsellors than social workers. Hence social work needs to take account of that wider perspective in formulating its own position on counselling.

Counselling skills can be applied in a variety of circumstances including indirect work, but in the counselling role they are consciously applied in combination as the central techniques for achieving change. There may be no other problem-solving or service- providing activity the counsellor engages in. Different kinds of skill are required according to the mode of interaction. Person oriented counselling tends to rely on such techniques as reflecting, paraphrasing, non-verbal attending, whereas in advisory work explaining, checking for understanding and summarizing are more prominent, though there is considerable overlap. All this point out to the reality that there is an urgent need to incorporate wellness counsellors to the social development sector.

5.9.5. **Conclusion**

Wellness counselors ought to work in diverse community settings designed to provide a variety of counseling, rehabilitation, and support services. Their duties must depend on their specialty, which is determined by the setting in which they work and the community they serve. Although the specific alignment may have an implied scope of practice, wellness counselors frequently are involved with children, adolescents, adults, or families that have multiple issues, such as mental health disorders and addiction, disability and employment needs, school problems or career counseling needs, and trauma. Counselors must recognize these issues in order to provide their clients with appropriate counseling and support.

Rehabilitation wellness counselors help people deal with the personal, social, and vocational effects of disabilities. They counsel people with both physical and emotional disabilities resulting from birth defects, illness or disease, accidents, or other causes. They evaluate the strengths and limitations of individuals, provide personal and vocational counseling, offer case management support, and arrange for medical care, vocational training, and job placement. Rehabilitation counselors' interview both individuals with disabilities and their families, evaluate school and medical reports, and confer with physicians, psychologists, employers, and physical, occupational, and speech therapists to determine the capabilities and skills of the individual. They develop individual rehabilitation programs by conferring with the client. These programs often include training to help individuals develop job skills, become employed, and provide opportunities for community integration. Rehabilitation counselors are trained to recognize and to help lessen environmental and attitudinal barriers. Such help may include providing education, and advocacy services to individuals, families, employers, and others in the community. Rehabilitation counselors work toward increasing the person's capacity to live independently by facilitating and coordinating with other service providers.

wellness counsellors are involved in the mental health counselling work with individuals, families, and groups to address and treat mental and emotional disorders and to promote mental health. They are trained in a variety of therapeutic techniques used to address issues such as depression, anxiety, addiction and substance abuse, suicidal impulses, stress,

trauma, low self-esteem, and grief. They also help with job and career concerns, educational decisions, mental and emotional health issues, and relationship problems. In addition, they may be involved in community outreach, advocacy, and mediation activities. Some specialize in delivering mental health services for the elderly. Mental health counselors often work closely with other mental health specialists, such as psychiatrists, psychologists, clinical social workers, psychiatric nurses, and school counselors.

another prevailing challenge in our society today is substance abuse and behavioral disorder which requires extensive counselling and helping people who have problems with alcohol, drugs, gambling, and eating disorders. They counsel individuals to help them to identify behaviors and problems related to their addiction. Wellness counseling can be done on an individual basis, but is frequently done in a group setting and can include crisis counseling, daily or weekly counseling, or drop-in counseling supports. Counselors are trained to assist in developing personalized recovery programs that help to establish healthy behaviors and provide coping strategies. Often, these counselors also will work with family members who are affected by the addictions of their loved ones. Some counselors conduct programs and community outreach aimed at preventing addiction and educating the public. Counselors must be able to recognize how addiction affects the entire person and those around him or her.

The high rate of divorce requires marriage and family therapists who must assist family breakdowns related challenges, principles, and techniques to address and treat mental and emotional disorders. In doing so, they modify people's perceptions and behaviors, promote communication and understanding among family members, and help to prevent family and individual crises. They may work with individuals, families, couples, and groups. Marriage and family therapy differ from traditional therapy because less emphasis is placed on an identified client or internal psychological conflict. The focus is on viewing and understanding their clients' symptoms and interactions within their existing environment. Marriage and family therapists also may make appropriate referrals to psychiatric resources, perform research, and teach courses in social development and interpersonal relationships.

Chapter 6: Literature Review
Wellness and Wellbeing: A Discussion of Empirical Models

6.1. Introduction

As previously discussed, the incommensurability of healthcare as well as the difficulty that healthcare professionals experience in diagnosing and treating clientele calls for an *integrated* method to screen for wellbeing. This chapter looks at previous and contemporary models of wellness to outline the essential features that an integrated method would need to incorporate for counsellors to use when screening for mood and anxiety disorders. Understanding these movements and changes to wellness is important in developing novel approaches to conceptualising wellbeing, a key feature of explicating new theoretical insights in grounded-theory perspectives (Birks & Mill, 2011; Wasserman, Clair, & Wilson, 2009; Fendt & Sachs, 2007; Tummers & Karsten, 2012; Human & Du Plessis, 2007).

Wellness itself has been viewed by the counselling profession as *the paradigm* in which to establish its guidelines, principles, and research (Myers, 1991, 1992). In fact, some would argue that the counselling discipline has always been focused on fostering and promoting wellness in its practice and theoretical developments (Myers, 1991). In turn, the concept of wellness has been heavily theorised and defined with some theorists seeing it as the antonym of 'illness' (Manderschied, Ryff, Freeman et al., 2010p p.1), with others viewing the term as the integration of various health dimensions (Hattie, Myers, & Sweeney, 2004). However, modern wellness definitions and understandings do have several common underlying threads that can be identified.

Conceptualising Modern Wellness

6.1.1. The father of modern wellness – Dunn.

Dr Halbert Louis Dunn is often regarded as the architect of the modern wellness movement (Hattie, Myers, & Sweeney, 2004; Miller, 2005). In contrast to previous understandings of wellness, Dunn identified a need to shift the focus from the suppressive aspects of illness and focus on promotive aspects of wellness. He used an allegory of older citizens to capture this sentiment (Miller, 2005):

Who can doubt…that the problems of elder citizens involve much more than just the saving of life or curing chronic disease? The great challenge at the older ages is how to keep a person fit until he dies, functioning as a dynamic unit in the population and contributing to society so that he can maintain his sense of value and dignity. It is quite possible that much of chronic disease could be eliminated if physicians knew how to recognize various levels of wellness. If, as seems certain, in the lower levels of wellness exist the precursors of future illness, it becomes increasingly important to recognize levels of wellness (p. 89).

Herein Dunn states a number of key concepts, which would become a part of his concept of wellness. The most important concept lies in in the reorientation from what is wrong with the patient or the elderly to what is right. Dunn reinforces this aspect by deeming the challenge of geriatric care lying not in the saving or curing of the elderly but rather keeping that person fit and contributing to society.

Dunn furthermore links the benefits of re-orientating wellness in elderly care to developing the individual's feelings of dignity and value. This focus on the positive aspects of wellness and the individual resound with the humanist trend in psychology, personified by the work of

Maslow and Adler as both theorists extensively promoted the development of an individual's sense of self-esteem and worth respectively. It also implicates the social dimensions of wellness as the development of the individual's self-esteem and worth is linked to the person "functioning as a dynamic unit in the *population* and contributing to *society*" (Dunn, 1959 as cited by Miller, 2005, p. 89, Author's italics).

Dunn's tying of elderly patients' feelings of dignity and value to their social environment further resonates with both Maslow's hierarchy of needs as well as Selye's (1955) general adaptation syndrome (GAS) and other theories of stress (Selye, 1986). They argue that a person's environment directly influences the behavioural choices they have, consequently affecting their beliefs and actions. Thus any understanding of wellbeing, according to Dunn, must show not only a concern for the individual, but also their social environment.

As it stands then, Dunn's conceptualisation of wellness denotes it as a dynamic concept that is concerned with not only a positive focus on wellness, but also a focus on the individual's own feelings of worth as well as those of their social environment. He further enforces his understanding of wellness as being dynamic by postulating that "it becomes increasingly important to recognise levels of wellness" Miller, 2005 p.89. By understanding wellness as comprising multiple levels and not merely as the definitive antonym of illness or disease, Dunn's conceptualisation allows a much more complex and multivariate understanding of wellness to take form. This understanding of wellbeing has been taken up and further modified by several other wellness researchers such as Travis and Don Ardell.

Dunn's understanding also resounded with the changes in healthcare in the 1950s (Miller, 2005) as well as the World Health Organization's own integrated concept of health as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity" (WHO Constitution, 7 April 1948 no 2, pp. 509).

Yet, for Dunn, the social and environment concerns of the individual were in effect only an element of seeking an *integrated* understanding of wellbeing. Dunn (1959a) had grown increasingly dissatisfied with medicine and healthcare, which he believed "are designed as though the sum total of [healthcare workers'] concern is for the body and the mind of man [sic]…. As if [healthcare workers] could divide the sum total of man [sic] this way" (p. 786-792). Instead, he saw that the task for wellness or wellbeing was to find a "rational bridge between the biological nature of man and the spirit", as for him, it was only through this that a "high level wellness for man [sic] and society, we cannot ignore the spirit of man in any discipline" (Dunn, 1959a, p.786-792).

In theorising ways in which to formulate a *rational bridge* between mind and body, Dunn emphasised a need to turn to religion, metaphysics, and energy field studies (Dunn, 1959a). He formalised this assertion stating that "high level wellness involves an interrelatedness of energy fields" (Dunn, 1961, p.22), thus acknowledging both the concept of energy fields (*inter alia,* social, personality, and magnetic fields and the interplay amongst them) and quantum physics[4]. With respect to current understandings in energy medicine and positive psychology, it could be argued that Dunn had foresight into the directions in which wellness or wellbeing would develop. He emphasised these ideas within his Health Grid model of wellness (Dunn, 1959a).

[4] This is discussed further in Chapter 3 in regard to Energy Psychology and through Field Therapy. It also highlighted when Dunn stated: "If self-integration deteriorates, it impedes the flow of energy and sets up resistance and crosscurrents which interfere with efficient functioning and can ultimately become destructive to body tissues, thus leading to psychosomatic or mental illness and death" (Dunn 1959b:450).

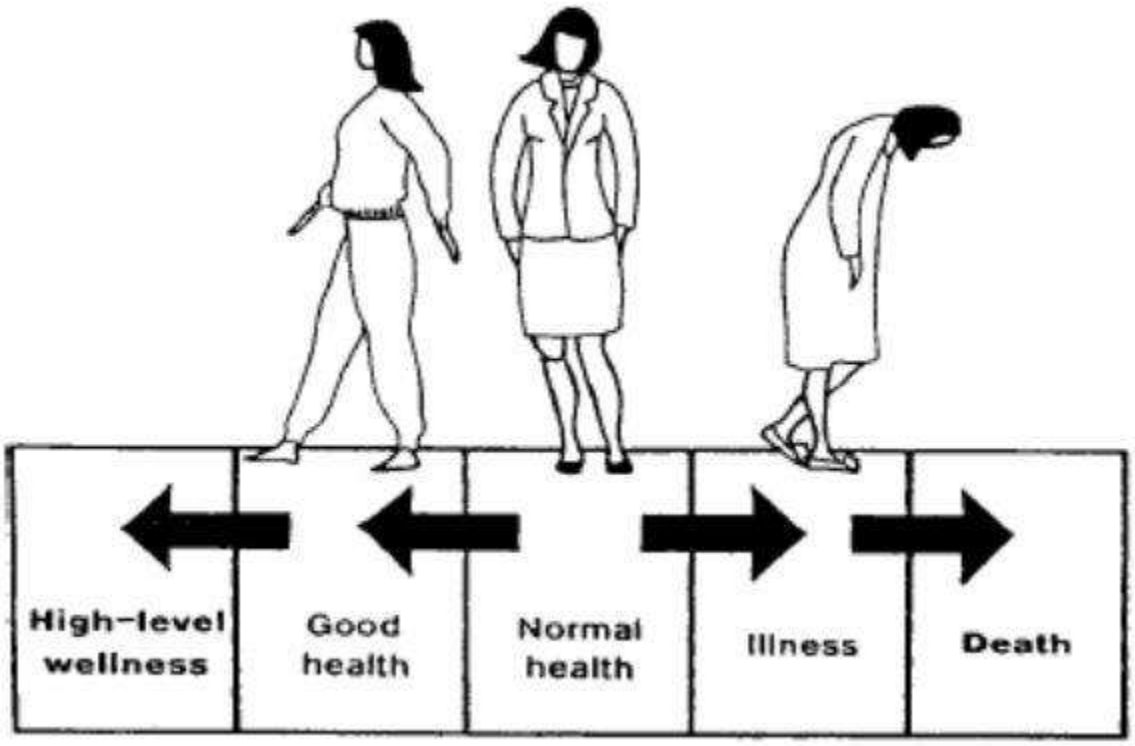


***Figure 6.1*: Dunn's Health Grid Model (adapted from Dunn, 1959a: 788)**

As shown in the figure above, the Health Grid comprises two axes: 1). a health axis which ranges from peak wellness to death, and 2), an environmental axis which ranges from being very favourable to very unfavourable. The two axes form four quadrants that can be generally designated into four types of wellness.

The first, a high-level wellness in a favourable environment can be seen when an individual who implements healthy life-style behaviours and has the biological, psychosocial, and spiritual resources to support this lifestyle. For instance, such a person would have the financial and social resources to live well, have access to affordable healthcare, and concentrates on maintaining their health through exercise or nutrition. In the second instance, emergent high-level wellness in an unfavourable environment occurs where an individual who has the knowledge to implement healthy lifestyle practices but does not implement adequate self-care practices due to family responsibilities, job demands, or other factors.

On the other end of the spectrum are those who have *protected poor health* in a favourable environment. This can be seen in, for example, an ill person whose needs are met by the health care system and has access to appropriate medications, diet, and healthcare instruction. The inverse, labelled *poor health*, occurs where a person lives in very unfavourable environments. This situation bears similarities to the rural poor in South Africa, where access to medical care or medicine is severely restricted (Woolard, 2002).

The views of psychoanalyst Erich Fromm and the humanist Carl Rogers greatly influenced Dunn's ideas of wellness (Miller, 2005). Furthermore, the concept of wellness as a matter of potential and movement along a continuum, rather than stasis was based upon the works of Gordon Allport's (1955) personality theory and Abraham Maslow's (1954) conceptualisation of self-actualisation.

Allport focused on the uniqueness of each individual and the importance of the present context in defining personality (Hjelle et al., 1992). He emphasised the importance of self-esteem and a *sense of self* in the development of the individual, positing that these provided the basis for emotional security and emotional ties with others (Allport, 1955). Maslow's (1954) self-actualisation contributed to Dunn's view of a *high level wellness*, that is, the ultimate goal towards which people should strive. In this, each theorist can be seen to be adding a piece of the puzzle to conceptualising an integrated philosophy of wellbeing wherein the uniqueness of the individual is paramount (Allport, 1955) as well as the behaviours they have access to (Maslow, 1954).

At this stage, it is useful to summarise the core principles of Dunn's work as they are still relevant today and have served as the foundation for more empirical studies. Firstly, by formulating wellness as a continuum, rather than a specific fixed state for all individuals, that is, located by an individual's particular circumstances, facilitates the idea that individuals are not bound to a single state of wellness. This formulation allows wellness or wellbeing to be a dynamic, changeable concept that individuals can maintain based on their unique situation. In this sense, wellness must be viewed in an integrated approach which includes physical, mental, social, cultural, and spiritual dimensions. More importantly, mental health is the preserve and responsibility of the individual and cannot be delegated to someone else. In this sense, wellness is about potential; from the counsellor's perspective, it involves helping the individual move along the continuum towards the highest state of wellbeing possible. In order to achieve wellbeing, it is the counsellor's preserve to develop an individual's self-knowledge and self-awareness, and a positive attitude, as they are key to progress the wellness continuum.

Dunn's (1977) formulation of wellness is particularly useful in developing any philosophy for wellbeing as it serves as a noteworthy example of an *integrated* theory of wellness. Whilst it draws upon several disciplines to inform its understanding, it unifies and considers the different streams it draws upon to be part of unified thread. The author's philosophy sees the work of Dunn and other theoretical resources drawn upon in a similar manner, in that while understandings of wellbeing or wellness have been conceptualised differently in other disciplines, a core unified understanding exists between each. By drawing upon an integrated formulation of wellness, Dunn (1977) suggested that counsellors were in a unique position to help individuals achieve a high-level wellness.

However, Dunn's conceptualisation of wellness places a very large amount of responsibility for patient-wellness on the counsellor, and very little is discussed about the patient's own role in facilitating their wellbeing (Miller, 2005). In regard to modern wellness theorisations and models, there has been some criticism regarding how the role of patient responsibility should be understood (Tuohimaa, n.d.). Dunn's lack of theorisation in regard to patient-responsibility could possibly reflect his resolve to encourage more health practitioner care that is focused on wellness. His contemporaries would both develop and display more regard for the patient's responsibility in subsequent wellness models.

6.1.2. Travis: Placing balance within wellbeing.

Travis' (1975) own conceptualisation of wellness measured through his *wellness inventory* placed a stronger emphasis on patient responsibility. It comprises 12 dimensions, ranging from self-love to nutrition, exercise, and one's social environment, which are employed to assess an individual's state of wellness (Miller, 2005). A significant precursor towards the development of the inventory was Travis' modifications to Dunn's (1959) Health Grid to form

a single continuum. In his wellness continuum, wellness is a neutral state where the individual is neither ill nor well which places premature death and high-level wellness on opposite ends of the continuum (Ardell, 1977).

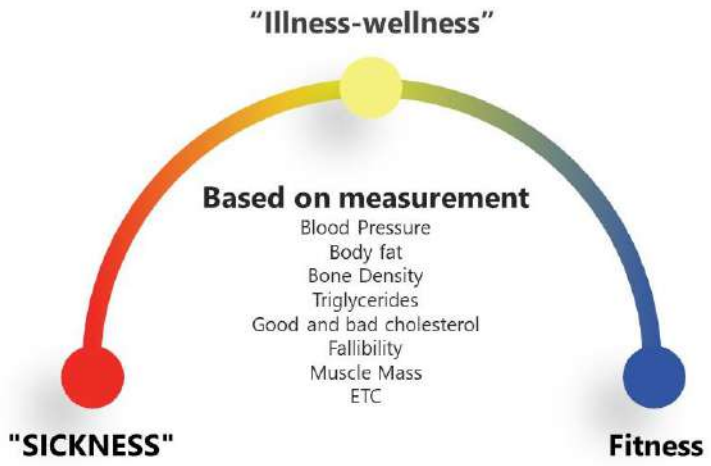


***Figure 6.2*: Travis' Wellness Continuum (www.thewellspring.com)**

Travis' revision of Dunn's model placed greater emphasis on individual responsibility for high level wellness; the central tenet being "if one knows oneself better, the better one is able to take care of one's self" (Travis & Ryan, 1977; 1981; 2004). This contributed significantly to popularising Dunn's (1959) philosophy of wellness (Miller, 2005).

In 1981, greatly influenced by Professor Ilya Prigogene's work on dissipative structures,[5] Travis published the Wellness Inventory (WI; also known as the Wellness Energy System). It conceptualised the body as an open system which takes in energy: oxygen through breathing; food through eating; and sensory stimulation (sensing) such as physical touch, heat, light, sound, and other forms of electromagnetic radiation (Well People, n.d.). In addition to these physiological inputs, Travis (1981) suggested that the less tangible inputs of emotional/spiritual information (attention, caring, enthusiasm, and love) have psychological and physical implications for wellbeing (as cited by Well People, n.d.). The three energy inputs are represented below in the Wellness Wheel, along with their energy outputs deemed the life-processes: *Self-Responsibility and Love, Moving, Feeling, Thinking, Playing and Working, Communicating, Intimacy, Finding Meaning, and Transcending.* Drawing together the inputs and output, Travis' (1981) model claims to be a complete wellness energy system of a human being noting that the 12 dimensions interact with one another and shape the life experience of a whole person's wellbeing.

[5] I.e., open systems in which energy is taken in, modified (transformed) and then returned (dissipated) to the environment.

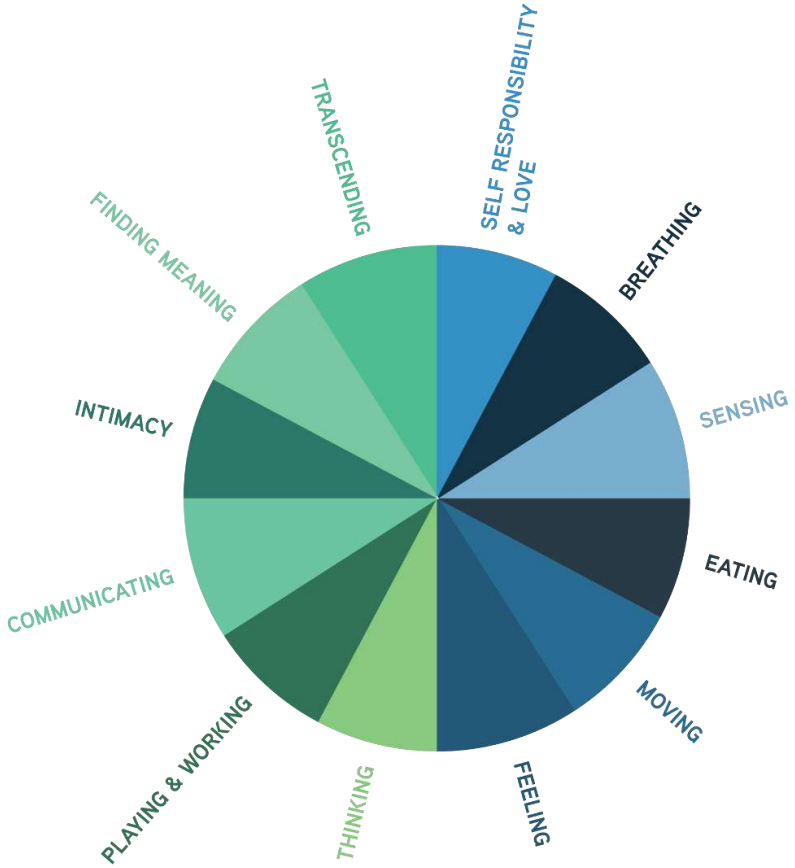


Figure 6.3: **Wellness Energy System (Travis and Ryan, 2004, pp. xxix)**

The WI contains 120 questions which measures the above mentioned life processes (Travis, 1981) These items for the WI are scored on a 1- to 5-point scale, from *no*, *never*, *hardly ever*, *usually*, or *yes always*. The lower the score on the item and total scale, the lower the level of personal wellness. For Travis (1981), self-responsibility and love are the primary expressions of life energy, together forming the *foundations* of wellness and encouraging the free flow of all other types of energy. This understanding of energy and emotional expression resonates in the works of Lipton (2008) and Goswami's (2004) formulation on the role of chakras and prana in the healing process within quantum physics..

Travis' (1981) model of wellness was one of the first to use a wheel as a heuristic (involving or serving as an aid to learning), for wellness. For the author, the wheel signifies the dynamic interaction between the twelve dimensions in informing the development and constant change of the individual's wellbeing. The simplicity inherent in this heuristic illustrating the changeable nature of wellbeing is taken into regard, as well as the use of life-processes that bear much similarity to the positive beliefs, emotions, and behaviour outlined by earlier theorists such as Dunn. Thus, it is not difficult to understand why the wheel of wellness has become a popular heuristic mechanism which has since been used by Witmer, Sweeney, and Myers (1998) in their Wheel of Wellness model, as discussed later in this chapter.

The author further notes that Travis' (1975) WI and his subsequent modifications seen in Travis and Ryan (1977; 1981; 2004) further stress the human interconnectedness of the 'whole person' wellbeing. Both the models of Dunn and Travis acknowledge the mind, body, and 'spirit' as an integrated concept. This repetition of the individual as an integrative unit is an important element to consider in formulating any integrated wellbeing method. However, Travis' (1975) WI comprising 120 questions is a very long and extremely comprehensive inventory, one which would be difficult to aid the development of quick and effective counsellor screening of client wellbeing.

6.1.3. Hettler: Wellness as multidimensional.

Another prolific model of wellness was provided by Dr Bill Hettler, co-founder of the National Wellness Institute (NWI) in 1976. The NWI was formed in 1977 to realise the mission to provide: health promotion and wellness professionals; unparalleled resources; and services that fuel professional and personal growth (NWI, n.d.). This model, commonly referred to as the Six Dimensions of Wellness, is shown below.

***Figure 6.4*: Hettler's 6 dimension model of wellness (NWI, n.d.)**

Following the development of the model, the Lifestyle Assessment Questionnaire (LAQ), a pen and paper test, was developed (now widely copied for USA campus wellness programmes) to assess the students' state of wellness on these six dimensions and provide help in encouraging long-term lifestyle change (Cooper, 1990)[6]. The questionnaire is divided into four sections: 'Wellness Inventory', 'Topics for Personal Growth', 'Risk of Death', and 'Medical Alert'. It contains 100 questions and measures 10 dimensions (NWI, 1983): physical fitness; physical – nutritional; physical - self-care; drugs and driving; social – environment; emotional awareness; emotional control; intellectual; occupational; and spiritual. These items are scored on a five-point scale, with lower scores reflecting lower levels of personal wellness.

It is noteworthy that the NWI continues to use this model[7]. This may be due to the sectional divide it contains in assessing personal growth; risk of death; and medical alert which can establish a respondent's immediate state of wellbeing. In this sense, the value of the NWI

questionnaire lies in its ability to assess wellness in multiple dimensions while it also gives insight into present or immediate concerns for the clinician or test-administrator.

Equally noteworthy is the fact that all the dimensions (emotional, occupation, physical, social, intellectual and spiritual) are accorded equal weight. This is in stark contrast to, for example, the work of Myers, Sweeney, and Witmer (2000) and others who place spirituality at the core of wellness. In this respect, the author finds the model, while being a useful heuristic device to understand wellness, to be too simplistic. In his understanding, it fails to engage with the complex ways in which these dimensions may interact with each other and the individual. For example, is the experience of traumatic death equal to the feelings of being intellectually unaroused and would both of these experiences have the same effect on a person's wellbeing? In this sense, while wellness is conceptualised as having several dimensions, the author finds it to be more like a one-dimensional model.

Moreover, although Hettler (1988) acknowledges the dimension of the intellect, and the interconnectedness of these dimensions, there is no provision for human growth and development. The notions of growth or self are not evident in any of the six dimensions, nor is there any evidence of how these dimensions may change from one context to another. Subsequently, this model ignores the important work of, inter alia, Fromm, Rogers, Adler, Jung, and Maslow who demonstrate the importance of positive thoughts, feelings, and beliefs for wellbeing.

6.1.4. Hinds: Wellbeing as lifestyle.

Hinds, like Hettler, was also a university-based health educator interested in health promotion. In 1983, he developed the Lifestyle Coping Inventory (LCI) to help individuals manage stress. The LCI contains 142 questions and comprises seven dimensions (Hinds, 1983). These dimensions focus on an individual's coping style actions; nutritional actions; physical care actions; cognitive and emotional actions; low-risk actions; environmental actions; and social support actions. Items for the LCI are answered on a 5-point continuum from *never* to *very often*; the lower the score, the lower the level of personal wellness (Hinds, 1983).

By focusing strictly on individual lifestyle choices, this formulation is problematic, as it marks the space for value-laden judgments or rather, 'Eurocentric' ideals of correct lifestyle choices which may be indirectly assessed. Hays PA (2001), Blaut JM (2012), Helms JE (1992). Also paramount is that any wellbeing measure should also take into account deeper facets that are not necessarily only linked to observable actions but also the deeper felt connections and investments of the respondent. Instead, the researcher sees lifestyle as only a piece of the puzzle that facilitates avenues towards wellbeing, rather than being all encompassing, as Hind (1983) would state.

6.1.5. Ardell: Rejection of 'spirit' or 'spirituality'?

However, there are many theorists, such as Donald Ardell, within wellness who would agree with Hinds (1983) that wellness measures and understandings should remain with the lifestyle choices an individual makes. As Miller (2005) notes, Ardell has little but contempt for any 'insight' that spirituality or belief may offer to understanding wellness. He stated that the wellness movement would be better off without its concern with the spiritual aspect:

The wellness movement in general…. [has been] oriented to such notions as mind/body/spirit, alternative healing methods… This has given many the impression that wellness is mushy, vague, New Age and quasi-religious (Ardell, 2004 pp. 84).

On closer inspection of this quote, the author argues that Ardell (2004) is not actually arguing against a spiritual component of wellness, but rather against the negative connotations that the term 'wellness' has. On Ardell's (2004) note of wellness having become a 'vague' concept, the author agrees. It is for this reason that the method under investigation is preferably labelled *an integrated wellbeing screening method.*

However, by excluding the notions of spirituality, or rather belief, from wellness, the secular discourse on wellness moulded on the humanist views of Ardell (2002) equates certain kinds of behaviour with 'virtue' and others with 'sin'. Following this logic, smoking or being overweight is a sign of moral weakness; while dieting and exercising is 'virtuous' (Crawford, 1984). One study of this wellness/morality nexus concluded that:

Concordant with the ritualistic nature of the wellness syndrome, forces of good and evil are pitted against each other in a morality play which takes the form of getting into shape (Nichter & Nichter, 1991: 256).

Placing morality into wellness places the individual under the spotlight by allowing their current attitudes, decisions, environment, and lifestyles to define them. This does not account for the manner in which stressors lead to responsive behaviour attitudes that the individual can adopt. The detrimental effects of such an understanding allows Gillick (1984) to note that this 'new gospel' of wellness served as a sort of secular path to personal salvation (Gillick 1984). Conrad (1994) accurately summarises the argument in saying that "in modern society, where health is such a dominant value, the body provides a forum for moral discourse and wellness-seeking becomes a vehicle for setting oneself among the righteous" (p. 398).

This can be viewed as placing a negative impact on the mind leading to negative thinking patterns and beliefs of the individual. Personifying the body as a moral reflection leads to the reification that wellness is the body and *not* the person. In this sense, the arguments of Hinds (1983) and Ardell (2004) for focusing strictly on lifestyle choices of the individual is a problematic formulation of wellbeing. As discussed above, it allows as many pathways to *not* having wellness as it does to living well. In this sense, an individual's lifestyle choices inform a part of conceptualising wellbeing and are not synonymous with the concept itself. Yet given the numerous different formulations already discussed, how reliable is the construct of wellness itself?

6.1.6. Palombi: Research into the psychometric properties of wellness measures.

At this stage, it is important to discuss the work of Palombi (1992). Since the term wellness was first introduced, a major issue facing wellness researchers and theorists has been how to assess levels of wellness accurately. Palombi (1992) assessed the psychometric properties of the three assessment tools, namely the Wellness Inventory (WI) (Travis, 1981), the Lifestyle Assessment Questionnaire - Wellness Inventory Section (LAQ) (National Wellness Institute, 1983), and the Lifestyle Coping Inventory (LCI) (Hind, 1983).

Palombi (1992) noted that although each of these methods were available to the public to assess a person's personal level of wellness, no test manuals providing norms, reliability, and validity existed. Furthermore, there was little evidence to establish whether these inventories did in fact measure the same construct of wellness, thus referencing issues of internal consistency, reliability, and construct validity which had not been addressed by the authors of these tests.

Palombi found that the WI, LAQ, and LCI demonstrated internal consistency and thus are reliable instruments, as a coefficient alpha of .93 was obtained for all three of the

instruments' total scales (Palombi, 1992). Thus, importantly, it can be inferred that wellness is an observable and measurable behaviour, with wellness instruments or models providing an indication of personal levels of wellness and the areas in which improvement may be needed. This information is of great importance to the counselling profession, thus validating their attempts to measure wellness and suggest and or provide the necessary interventions. As Palombi (1992) puts it, "wellness inventories could provide a focus for psycho-educational programming by targeting the wellness dimensions that need to be improved" (p. 221-225).

In this context, psycho-education is paramount in that people are misinformed about what well-being actual entails. This curtails the attempts at improving wellbeing understandings as people are still bombarded by the hegemony surrounding wellness which in turn leads to the misrepresentations of wellbeing seen on the internet, television programmes, and the products found in society today. Thus, this calls for a philosophy of wellbeing that places education at the forefront of an integrated screening philosophy that can lead respondents towards facilitating wellbeing in their own lives, as Dunn (1959) originally envisioned.

6.1.7. Critiquing modern wellness or wellbeing conceptualisations.

Modern conceptions of wellness or wellbeing developed in response and in reaction to Dunn's (1959) original conception constitute a fruitful ground in which to identify core features that could possibly advise the development of an integrated method to screen for wellbeing. Nonetheless, these understandings of wellness or wellbeing are far from ideal and have been problematised on a number of grounds.

Perhaps the most pertinent to the aims of this research and the understandings previously discussed relates to the role of patient responsibility. Certain scholars argue that the negation of client-responsibility is tantamount to negating the element of choice involved in lifestyle and wellness decisions, while others problematise patient-responsibility as inciting blame by health practitioners on patient lifestyle decisions (Tuohima, n.d.). These issues are inherently intertwined with wellness, encompassing the social environment, free-will, politics, and economic spheres of their lifestyles, and in turn, a client's own feelings of empowerment in the counselling process. In effect, questions surrounding the role of patient-responsibility deal with the amount of control patients or clients have in their own lives (Tuohima, n.d.).

Mol (2009) specifies that these issues regarding patient choice and responsibility can be redirected through the "logic of care", which curtails the issues related to wellness decisions made by the patient. She uses the example of a diabetic who fails to properly record his insulin levels due to lifestyle conditions beyond his control. She discusses the inability of healthcare practitioners or clients to fully control any situation, asserting that care should be the main praxis by which patient responsibility is determined (Mol, 2009). Thus, despite the patient experiencing difficulty in being responsible for their own well-being, it is up to practitioner to account for, adjust, and implement new care strategies to do the best with the resources available. Here, patient-responsibility is completely bypassed, and it is the health practioner's role to account for either the lack of availability of responsibility of the patient regarding their wellness.

The question within this frame of patient responsibility lies within the self-empowerment, feelings of worth, and value that Dunn, Travis, and several other wellness theorists described. It is hard to enculture values of maintaining and developing one's own wellbeing while placing others, not oneself in charge. (Cappelen, *et al*. 2004,) and Cappelen and Norheim (2004) engage the possibility of re-orientating patient-responsibility by contextualising patient decisions in terms of present and future possibilities. In this light, by

engaging the patient in taking responsibility for their wellness when choices are made by the individual rather than when the consequences materialise, responsibility is still accounted for while blame is curtailed (Cappelen & Norheim, 2004). This is still not a conceptualisation that is not problematic as it fails to account for structural factors and a method to develop such 'charge-taking' responsibility in patients. It does, however, illustrate that while models of wellness and wellbeing advocate the patient's own role in maintaining their wellness, many fall short of recognising and developing how their model will account for developing responsibility in patients.

A further problem with models of wellness is linked to the individual's accountability for their wellness. This can be best described by utilisation of wellness concepts in corporate companies to discipline and manage employee health. Haunschild (2003) discusses how employee health promotion can be tied to Foucault's own power/ knowledge and discipline arguments, where the regulation of employee wellness behaviour constitutes power over them, in terms disciplining them to adopt "normative" practices. This postmodern approach to wellness or wellbeing concepts being utilised in the workplace details how defining and setting certain criteria regarding what constitutes wellness behaviour. It also holds individuals completely accountable for it can move away from the emphasis that wellness models place on free-will and self-worth which further entrap individuals into adopting practices that work to undermine these values (Haunschild, 2003).

In addition to this, Einstein and Shildrick (2009) also illustrate how postmodern theories of wellness and health can provide potential avenues into deconstructing modernist divides between: illness vs wellness, female vs male, sex or gender and the notion of an autonomous body. They highlight how the typical normal body often defined in health does not adequately encompass all men and women, nor the type of care they have access to or the support structures in a particular choice of lifestyle. These raise fundamental issues in regard to normalising trends of what constitutes wellness or wellbeing in different situated experiences of individuals (Einstein & Shildrick, 2009). It also lays claim to the issues involved in stating that wellness or wellbeing of a British man in his forties is similar to those of a fourteen year old Maori girl. Models of wellbeing that essentialise categories and aspects of wellness can fail to grasp the differences of situated and lived experiences (Einstein & Shildrick, 2009).

Sarvimaki (2006) completely problematises the essentialising characteristics of modern wellness conceptualisations by drawing upon Heideggerian theory. She argues that the Gestalt mantra (Wagner-Moore, L.E.2004), of "the whole is greater than the sum of its parts" is difficult to rationalise as "if Being is the sum of separate parts, it is not conceived as a whole being… well-being may well be conceptualised as physical, mental, social and spiritual… but in order to gain a deeper understanding of well-being we have to transcend the division of well-being" (p. 5). In other words, the understanding of well-being being composed of separate elements of different lifestyle spheres, still underlies a split understanding of wellbeing. The same notion occurs for understanding wellbeing as the antonym of illness; it relies on value judgment of "good" versus "bad" behaviours. The splitting and valuing of behaviours and thoughts calls into question how well-being has been defined, and ignores the "being" aspect of "being well" (Sarvimarki, 2006). In turn, it could be said that a compartementalised and value-laden understanding of well-being falls short of how wellness is actually lived and experienced by all.

Thus, these critiques serve as reminders that the empirical models based on modern conceptualisations of wellbeing discussed below are problematic. Identifying these critical

issues in developing an integrated well-being screening method outlines possible areas wherein well-being as a concept can be further developed.

Contemporary Empirical Models of Wellness

Health is not simply the absence of disease: it is something positive. (Henry Sigerist, Medicine and Human Welfare)

The author's concern with creating an integrated wellbeing screening philosophy resounds with the resolution of the American Association for Counseling and Development (AACD) entitled *The Counseling Profession as Advocates for Optimum Health and Wellness*. This declaration represented not only a commitment to an integrated wellness within a developmental guidance approach but also a firm avowal of wellness as *the* paradigm for counselling. This adoption reflects the move to an integrated understanding of wellbeing. As Larson (1999) notes by furthering an understanding of wellness as being integrated: "the prospects for improving medical outcomes and the quality of care are enhanced" (p. 123).

Earlier understandings of wellness/being, seen in the works of Dunn and Travis situate wellbeing on a continuum wherein one's environment, beliefs, and emotions can work negatively towards illness or positively towards their wellbeing. More importantly, these understandings stipulate that any work towards creating an integrated wellbeing philosophy must see wellbeing as a dynamic concept, which encompasses much more than an individual's lifestyle, and as Hindler noted, should also address immediate wellbeing concerns for the respondent.

However, these earlier models also specify that any integrated screening philosophy must also take into account the length of the inventory and must accommodate different lifestyle choices without being morally biased. Furthermore, with the exception of Palombi's (1992) work, Ryff and Keyes (1995), and Chandler, Holden, and Kolander (1992) noted the absence of empirical studies in wellness or wellbeing. Ragheb (1993:22) called for a "wellness measure, valid and reliable, to assist practitioners and scientists".

These concerns prompted the need to investigate more contemporary inventories and models of wellness/being such as the Wheel of Wellness of Myers, Sweeney, and Witmer (1991, 2003; the Indivisible Self model (Myers & Sweeney, 2005) as well as The Perceived Wellness Survey (PWS), and the Wellness Behaviour and Characteristic Inventory (BMS-WBCI). These models demonstrate the interrelatedness of various wellness dimensions (Hey, Calderon, & Carroll, 2006), as well as cognitivist and positive psychological theories. Het et al. (2006) note that in this context it is easy to neglect spiritual wellness, but that this dimension must be considered, as such theoretical constructs as self-efficacy, motivation, self-control, and other action cues can all be related to, or may even be representative of, spiritual wellbeing as evident in the formulations of earlier models discussed previously.

6.1.8. The wheel of wellness.

In contrast to the previously discussed models of wellness which emanated from the physical health sciences or public health, Myers, Sweeney, and Witmer's (1998) "wheel of wellness" was firmly situated within the counselling profession. The model reflected the AACD's commitment to wellness as an integrated concept and Myer's (2000) own views of wellness as:

a way of life oriented towards optimum health and well-being, in which body, mind and spirit are integrated by the individual to live life more fully within the human and natural

community. Ideally, it is the optimum state of health and well-being that each individual is capable of achieving (p. 252).

In the said wheel, wellness is considered to be a set of proposed relationships between twelve components (later expanded to seventeen), which were derived from the reviews of Myers, Sweeney, and Witmer (1998; 2000) regarding cross-disciplinary studies that sought to identify the correlations between health, quality of life, and longevity. The model is based on the works of psychoanalyst Alfred Adler (1927/1954) with respect to life tasks for the self (Ansbacher & Ansbacher, 1967; Sweeney, 1998; Myers et al., 2000), using it as the basis to help define the components of wellness.

Each of these twelve components of wellness interacts with contextual and global forces to influence the sum of a person's well-being (Myers et al., 2000). As Erlandson, Harris, Skipper, and Allen (1993:17) emphasise, no two contexts are alike, and modes attempting to create full generalisability (within the paradigm of wellness) "ignore(s) the unique shaping forces that exist within each context". This is important as it allows for an exploration of each individual's unique context surrounding their wellbeing. In turn, the interaction between components allows avenues into treating the cause(s) surrounding an individual, for example the relationships of an individual, can impact many aspects of their wellbeing such as their mental, emotional, or even environmental situation (seen extensively in the Grant Study, Viallant, 2012).

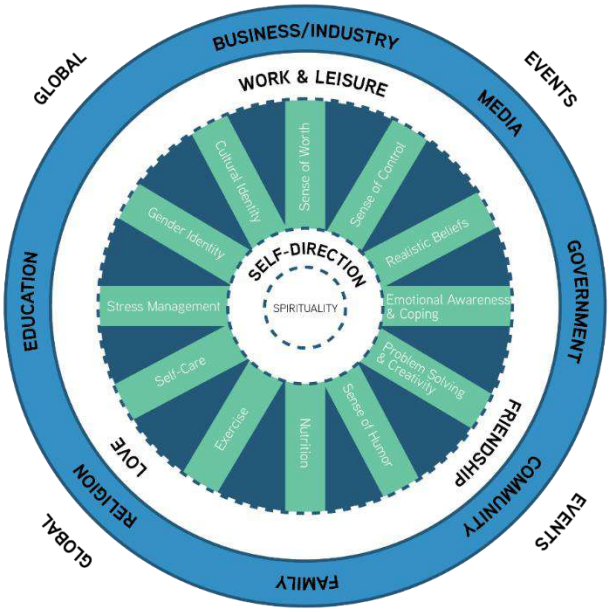


Figure 6.5: Wheel of Wellness (Meyers & Sweeney, 2008, p. 235)

At the core of the wheel of wellness or the interaction between the components of wellness, is "spirituality". According to Myers et al. (2000), their view of spirituality includes the concepts of "a sense of meaning in life, in addition to religious or spiritual beliefs and practices" (as cited by Myers & Sweeney, 2008). It is important to note here that *spirituality* does not necessarily mean religious belief, but rather the beliefs a person has acquired which informs their understanding of wellbeing.

Radiating from the centre of spirituality are the twelve "spokes" or components of wellness, which are defined as self-directed life tasks. The tasks are outlined by Myers, Sweeney, and Witmer (1998) as: "sense of worth", "sense of control", "realistic beliefs", "emotional awareness and coping", "problem solving and creativity", "sense of humour", "nutrition", "exercise", "self-care", "stress management", "gender identity", "cultural identity". These spokes help to regulate or direct the self as a person responding to the Adlerian life tasks of "work and leisure", "friendship", and "love" (as cited in Myers et al., 2004). These are important concepts as they stimulate the relaxation response in the individual as they move through their everyday life.

The view of wellness involving "problem solving and creativity" is important as it reverberates not only cognitivist understandings of human perception and memory, as in the information processing model (see Chapter 4), but also links to quantum physics in the realm of spirituality and healing (see Chapter 2)[8]. In this sense, the model demonstrates the need for an understanding of wellbeing, which not only integrates several components, but can also incorporate different theoretical paradigms.

Another example found in the Wheel of Wellness lies in the interactive nature of the "spokes" of wellness which stipulates that change in one area causes or contributes to changes in other areas. This resonates with General Systems Theory (von Bertalanffy,1972;recognising that for a complex system such as the human body, to endure is not sufficient; the system must be able to adapt itself to modifications of the environment or face entropy. According to Mattessich (1982), systems thinking is first and foremost a point of view and a methodology which replaces reductionism or *analysis* (the belief that everything can be reduced to individual parts) with *expansionism* (the belief that any system is always part of a larger system) (Pourdehnad et al, 2011; Da Vinci, 2012). It can also be argued that General Systems Theory resonates with many principles of quantum mechanics and chaos theory (see Brant, 2009; Gleick, 1988).

The value of systems theory in the development of a screening philosophy for the counsellor is its view of the client's wellbeing as a *complex system*, requiring *proactive* management to *adapt*[9] to forces in the environment. This resounds with Jones' (1934) statement that "guidance is based upon the fact that human beings need help … in order that a decision may be made wisely" (p. 3). Thus, such an understanding would allow counsellors to see the *patterns of interrelationship* and the *connectedness* of the various aspects of their clients (the "system") –termed "synthesis" by Ackoff (1981)– rather than their clients as experiencing discrete "events" or "problems" in their wellbeing.

The value of this model of wellness for an integrated well-being philosophy for the counselling profession is twofold. Firstly, it provides a diagram to unify the many dimensions of wellness, thus highlighting core aspects of the self that resonates with aspects of the wellness models of Dunn, Travis, and Hettler who placed a similar emphasis on their model. However, with regard to the unifying core element of spirituality, the model takes an interesting step to place belief as a necessity in understanding the relation between mind and body in well-being. Yet, the relation is vague and needs deeper clarification as the concept remains ambiguous (i.e., is spirituality versus belief versus religion). Secondly, the

[8] For example, Goswami (2012) notes the potential of human beings to make quantum leaps within their wellbeing as demonstrated by a number of studies that demonstrate the links between spirituality, creativity, and problem solving in their gross and subtle bodies that highlight the interconnectivity between aspects of a person's wellbeing.

[9] As in a developmental approach.

WOW led to the development of the Wellness Evaluation of Lifestyle (WEL) which provides a useful inventory that identifies the components of wellness discussed next.

6.1.9. WEL Assessment based on the WOW.

The Wheel of Wellness (WOW) is the basis of an assessment instrument, the Wellness Evaluation of Lifestyle (WEL) (Myers, Sweeney, & Witmer, 1998). It has been used extensively in empirical studies as well as anecdotally, remaining a useful tool for professional counsellors to use as a guide for both formal and informal assessment, and in turn, wellness-oriented counselling. Developed to assess each of the five life tasks and subtasks in the WOW by Myers et al., who spent six years conducting quantitative research to field test and improve the psychometric properties of the instrument (Hattie et al., 2004)[10].

Feedback from the counselling profession in the USA allowed the authors to validate their positioning of spirituality as the core characteristic of wellness, and they state that it has an "intuitive" and "almost universal appeal" (Myers & Sweeney, 2008). In determining the validity of the WEL compared with other assessment measures, Myers (as cited by Hattie et al., 2004) conducted research over a four-year period comparing the WEL scores with, inter alia, Hettler's (1984) hexagon model (now marketed by Test Well). She concluded that the WEL compares favourably with most instruments which have similar scale definitions (as cited by Hattie et al., 2004). Previous reliability scores of the said instrument indicate an internal consistency of the 17 subscales ranging from .61 to .89 (Myers et al., 2000). Numerous studies have used, and continue to use, the WEL to measure wellness. The author cites just one instance, the work of Parsons (2006) who used the WEL to explore wellness behaviours of first year college students. Although she used all 17 subscales (from the five life tasks), subscales with a Cronbach alpha at or above .70 included Total Wellness (.88), Love (.80), Sense of Worth (.73), Exercise (.82), Spirituality (.82), Stress Management (.79) and Nutrition (.78) (Parsons, 2006).

However, Myers and Sweeney (2008) later noted that statistical analyses failed to support the hypothesised circular structure and the centrality of spirituality relative to other components of wellness. This suggested that their research was leaning towards a new model. Revising their understanding, Myers et al. (2000) defined wellness as a cumulative effect of several factors associated with human behaviour and effects of life's demands. They stated that wellness (as an entity) should replace "spirituality" at the core of the "wheel" with the then five second-order dimensions of Creative Self, Coping Self, Social Self, Essential Self, and Physical Self defining the rims of the wheel[11]. This led to the development of the Indivisible Self model, discussed next.

6.1.10. The indivisible self (IS-WEL).

Hattie, Myers, and Sweeney (2004) analysed a large database developed during their research using the WEL inventory. Using structural equation modelling, these authors constructed a hypothesis with a three-level factor structure; this included a single higher order wellness factor, that is, the indivisible self, based on the total number of items in the

[10] Their estimates of reliability (coefficient alpha) were high enough to allow a meaningful interpretation of the scores. Significantly, these test found that the total sample scored high on Love, Friendship, and Self Care, and the lowest mean scores were for Realistic Beliefs, Nutrition, Work, and Exercise, which resounds with similar findings of the Grant study.(Vaillant G.E (2012)

[11] As discussed in Chapter 4, these aspects of self in the ISWEL strongly correlate to the archetypes of gross and subtle bodies identified by Goswami (2011). These bodies which connect Goswami's (2011) spiritual archetypes of physical, vital, supramental and bliss to Jung's (1971) sensing-type, feeling type, thinking type, and intuitive type allow for conscious possibilities in the material, vital, mental, and supramental spheres.

WEL inventory and five second-order factors. The five second-order factors are: the Creative Self, the Coping Self, the Social Self, the Essential Self, and the Physical Self. The third level is the context of the self, that is, one's environment.

Although Hattie et al. (2004) confirmed the original 17 components of the WOW as being discrete third-order factors, the components did not fall into the groups that Myers and Sweeney (2003) had theorised. Sweeney and Myers (2003), greatly influenced by Adler, then developed the Indivisible Self (IS-Wel) model (see Figure 2.5) as an evidence-based model of wellness.

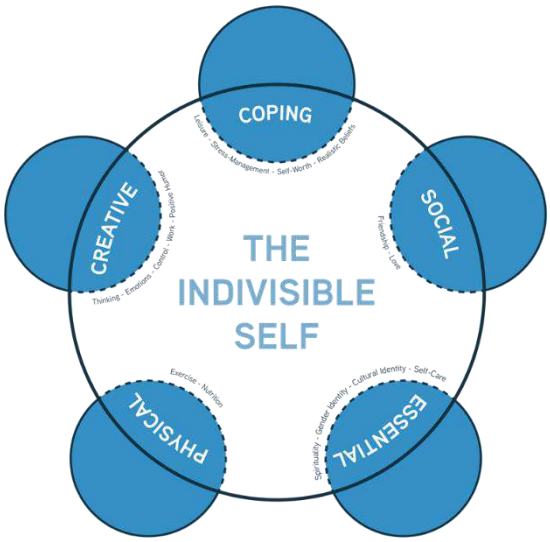


***Figure 6.6*: The Indivisible Self, as cited by Hattie et al., 2004, p. 39**

Adler (1927/1954) believed in the unity and indivisibility of the self, stating that human beings constitute more than the sum of their parts and cannot be divided[12]. The unified nature of personality, according to Adler , A(1954), is represented in this model as the "Indivisible Self", that is, the dimensions of the Creative Self, Coping Self, Social Self, Essential Self, and Physical Self overlap and interact to the extent that a dominant "higher order" Wellness Factor is evident as the "Self" (Hattie et al., 2004). This magnifies the concept of "holism" in that there are no exact borders to be drawn between the elements of self, thus avoiding dualism. Yet once again, as with other models of wellness, the overlapping of the different selves has not been ascertained or fully constructed in this model.

Table 3.1 is an explanation of the dimensions that underlie the five second-order factors of this model. The contexts are shown at the bottom of the table with concomitant explanations; however, they apply to all of the five second-order factors.

Table 6.3
Explanation of the IS-Wel (adapted from Hattie et al., 2004)

TOTAL WELLNESS	**The sum of all items on the 5F-Wel; a measure of one's general well-being or total wellness.**
Creative self	**The combination of attributes that each of us forms to make a unique place among others in our social interactions and to positively interpret our world.**
Thinking	Being mentally active, open-minded; having the ability to be creative and experimental; having a sense of curiosity, a need to know and to learn; the ability to solve problems.
Emotions	Being aware of or in touch with one's feelings; being able to experience and express one's feelings appropriately, both positive and negative.
Control	Belief that one can usually achieve the goals one sets for oneself; having a sense of "planfulness" in life; being able to be assertive in expressing one's needs.
Work	Being satisfied with one's work; having adequate financial security; feeling that one's skills are used appropriately; the ability to cope with workplace stress.
Positive humour	Being able to laugh at one's own mistakes and the unexpected things that happen; the ability to use humour to accomplish even serious tasks.
Coping self	**The combination of elements that regulate one's responses to life events and provide a means to transcend the negative effects of these events.**
Leisure	Activities done in one's free time; satisfaction with one's leisure activities; having at least one activity in which "I lose myself and time stands still".
Stress management	General perception of one's own self-management or self-regulation; seeing change as an opportunity for growth; ongoing self-monitoring and assessment of one's coping resources.
Self-worth	Accepting who and what one is, positive qualities along with imperfections; valuing oneself as a unique individual.
Realistic beliefs	Understanding that perfection and being loved by everyone are impossible goals, and having the courage to be imperfect.
Social self	**Social support through connections with others in friendships and intimate relationships, including family ties.**
Friendship	Social relationships that involve a connection with others individually or in community, but that do not have a marital, sexual, or familial commitment; having friends in whom one can trust and who can provide emotional, material, or informational support when needed.

TOTAL WELLNESS	**The sum of all items on the 5F-Wel; a measure of one's general well-being or total wellness.**
Love	The ability to be intimate, trusting, and self-disclosing with another person; having a family or family-like support system characterized by shared spiritual values, the ability to solve conflict in a mutually respectful way, healthy communication styles, and mutual appreciation.
Essential self	**Essential meaning-making processes in relation to life, self, and others**
Spirituality	Personal beliefs and behaviours that are practised as part of the recognition that a person is more than the material aspects of mind and body.
Gender identity	Satisfaction with one's gender; feeling supported in one's gender; transcendence of gender identity (i.e., ability to be androgynous).
Cultural identity	Satisfaction with one's cultural identity; feeling supported in one's cultural identity; transcendence of one's cultural identity.
Self-care	Taking responsibility for one's wellness through self-care and safety habits that are preventative in nature; minimising the harmful effects of pollution in one's environment.
Physical self	**The biological and physiological processes that compose the physical aspects of a person's development and functioning**
Exercise	Engaging in sufficient physical activity to keep in good physical condition; maintaining flexibility through stretching.
Nutrition	Eating a nutritionally balanced diet, maintaining a normal weight (i.e., within 15% of the ideal), and avoiding over-eating.
Context	
Local context	Systems in which one lives most often families, neighbourhoods, and communities and one's perceptions of safety in these systems.
Institutional context	Social and political systems that affect one's daily functioning and serve to empower or limit development in obvious and subtle ways, including education, religion, government, and the media.
Global context	Factors such as politics, culture, global events, and the environment that connect one to others around the world.
Chronometrical context	Growth, movement, and change in the time dimension that are perpetual, of necessity positive, and purposeful.

The creative self.

The first factor, the Creative Self, comprises coping skills such as problem solving and creativity, sense of control, emotional awareness and coping, sense of humour, and work. This reverberates with what Adler (1954) would consider to be coping skills for day-to-day

life; that is, problem solving and creativity, sense of control, emotional awareness, and coping, sense of humour, and work. A long tradition of research into behaviours associated with these elements' points to their considerable effects on both longevity and quality of life (Myers et al., 2000). This has also been demonstrated in the work of Lisa Rankin (2013), whose research suggests that there are links between emotional awareness and physiological wellbeing.

The coping self.

In comparison, the Coping Self comprises Leisure, Stress Management, Sense of Worth, and Realistic Beliefs, components which provide a means to respond to the circumstances of life in a manner that promotes healthy functioning. Here, the influence of the cognitive behaviour theory is evident as each of the aforesaid aspects involves some degree of cognitive processing, intentional behaviour, and active response, as well as insight into the stress-response studies previously discussed.

The authors state that they were influenced by Lazarus's (1999) concept of active coping, but emphasised the individual's efforts to derive satisfaction from an idiographic perspective (Hattie et al., 2004), believing satisfaction, stress, and "reality" to be literally in the eye of the beholder. In this it is once again suggested that perception leads to stress, which in turn leads to response, as Adler believed everyone is presented with certain social opportunities and challenges (Adler, 1956, pp. 127–131; Sweeney, 1998, p. 216, 240).

Thus, individuals who construct a "private logic" permitting one to cope successfully in life in everyday interactions with others are also more likely to experience what we call wellness (Hattie et al., 2004).

The social self.

While the Coping Self and the Creative Self deal with day-to-day aspects of the individual, the Social Self highlights an individual's inter and intra personal life. This includes the key life tasks of love and friendship. Noting that the literature blurs the distinction between these two concepts, Hattie et al. (2004) note that it is less important to differentiate between love and friendship than to acknowledge that studies of longevity and life satisfaction underscore the vital role of social relationships throughout the life span. The Grand Study elaborates significantly on the importance of social relationships, especially positive ones and well*being* (Vaillant, G.E. 2012). A recurring theme in all the models discussed is the concept of love, positive emotions, and wellbeing.

The essential self

The uniqueness of the individual is comprised within the Essential Self. This dimension includes, but is not limited to, the original concept of spirituality, as placed by Meyers et al. (1998) at the centre of the WOW. Purposiveness, meaning in life, and a sense of a power greater than one's self all contribute to this dimension. These aspects, in combination, contribute to distinguishing humans as being intrinsically and fundamentally unique (i.e., their spirituality or essence).

However, in this model, Hattie et al. (2004) and Myers, Luecht, and Sweeney (2004) note that rather than being the core characteristic of wellness (as in the WOW), the essential self maintains a statistical level of importance *equal* to that of the other four higher order factors (as discussed). Further, the authors note that the essential self includes aspects of optimism; thus closely aligned with what Marshall, Wortman, Vickers, Kusulas, and Hervig

(1994) termed “optimistic control”, which includes aspects of having faith in one’s abilities and the capacity to derive meaning from life (Hattie et al., 2004).

The Essential Self also includes elements of what Hattie et al. (2004) term “self-definition”, that is, culture and gender identity issues. The authors also note the dynamics in taking care of one’s self as being important, for example, not engaging in self-destructive behaviours (i.e., using illegal drugs) and actively seeking out preventative medical assistance (Myers, 2008; Hattie et al., 2004). Individuals without a purpose or direction in life, that is, those lacking in optimism or hope, are at higher risk for both mental and physical “dis-ease”. In other words, without an essential sense of wellbeing, there is less motivation for self-care.

The physical self

While the focus falls on the other “selves”, the individual’s social and psychological aspects, *the Physical Self highlights the importance of the body in wellness.* It is not surprising to realise that exercise and nutrition, the components of the physical self, together, and in concert with the psychological factors mentioned in the four other “selves”, comprise a well person. Previous models of wellness tended to emphasise the physical aspects of health (as noted in the introduction) to the exclusion of psychological aspects. Myers and Sweeny (2005) thus deemed “holism” to be the explanation of the new model; that is, the self is at the core of wellness, as depicted graphically (and ultimately statistically) as indivisible.

Discussion of the model.

The stress on holism of the Indivisble Self is important, as is their emphasis on the importance of context; wellbeing does not occur in a vacuum, and the degree of wellbeing is determined in part by one’s context, or environment. Thus Hattie et al. (2004) note various contexts, that is, local, institutional, global and chronometrical, as mitigating factors in wellness. The acknowledgement of different contexts and their various interactions with the individual, acknowledges the dynamic nature of the individual and their wellbeing, as well as the concept’s fluidity in different settings. As at 2008, empirical studies had been conducted on only one context, that is, the local one; the research carried out by Tatar and Myers (2010) supports this as a factor for overall wellness.

Regarding correlates of wellness, multiple studies exist using the WEL and 5F-Wel which include the effects on wellness levels of psychological traits, employee characteristics, ethnicity and acculturation, emotional connections, through to mattering and attachment to companion animals, relationship issues, and other characteristics. Many of these are cited by Tatar and Myers (2010) in their research. However, as psychological traits are particularly important, especially regarding a screening philosophy for counsellors, research into WEL/5F-Wel correlates are discussed next.

In one of the earliest studies on wellness, Hermon and Hazler (1999) found that both short-term state and long-term trait constructs of psychological well-being correlated positively with each of the major life tasks in the WOW for undergraduate students. Sinclair and Myers (2004) studied the relationship between components of objectified body consciousness and wellness in heterosexual, Caucasian women, finding a negative relationship between body shame and wellness and a positive relationship between appearance, control, beliefs and wellness. Makinson and Myers (2003) used structural equation modelling to demonstrate that social interest explained a significant portion of the variance in wellness among adolescents; finding only a weak relationship between moral identity and wellness.

An interesting study in South Africa was conducted by Amery (2005) who used the 5F-Wel for a sample of oncology nurses in South Africa and noted lower wellness levels in this

population compared with wellness levels for the norm sample for the instrument. Myers, & Sweeney (2008) suggests that the stress related to cancer is a major factor that influenced these findings. Many studies have shown that perceived stress has an inverse relationship with wellness (Degges-White, Myers, Adelman, & Pastoor, 2003; Powers, Myers, Tingle, & Powers, 2004; Myers & Bechtel, 2004; Gibson & Myers, 2006; Myers & Degges-White, 2007). Citing these studies, it can be suggested that the human stress-response leads to the elicitation of negative feelings implying a need to "care for the core". Thus, the stresses of cancer not only cause physical reactions, but beliefs, attitudes, and behaviours about cancer itself. Isolating only one of the physical factors does not care for the core, as beliefs that nurses hold about cancer can also impact the cancer's course, suggesting a deeper relation between beliefs, emotions, and physical symptoms.

These empirical findings as well as the various dimensions of the WEL and IS-WEL stipulate that these dimensions are more than merely personality attributes, because they are closer to various goal strivings or virtues, in that they are nomothetic, idiographic, and personalised motives (Emmons, 1986 as cited by Hattie et al., 2004). The author finds the word "virtue" particularly useful, as it denotes and finds commonality with the work of previous wellness models between beliefs, emotions, and behaviour, for example, the model of Dunn, Travis, and Hettler. Consider for example, the aspects of friendship and love comprising the "Social Self", which are respectively defined as:

Friendship: Social relationships that involve a connection with others individually or in community, but that do not have a marital, sexual, or familial commitment; having friends in whom one can trust and who can provide emotional, material, or informational support when needed.

Love: The ability to be intimate, trusting, and self-disclosing with another person; having a family or family-like support system characterized by shared spiritual values, the ability to solve conflict in a mutually respectful way, healthy communication styles, and mutual appreciation.

Both of these aspects can be rearranged under the single virtue of love, as love signals not only the behaviour of being intimate and of sharing a connection with others that is premised on the emotional state of trust (seen in both definitions), as well as the belief of shared values. Similarly, the components of the other selves of the Indivisible Self resound with the notions of virtues, in that each relays a relationship between the beliefs, emotions, and behaviour of the individual in facilitating their wellbeing. Considering Myers & Sweeny's(2008) research in such a light, it displays how beliefs and emotional states can lead to physical symptoms

In other words, the goals or virtues that are bound up in the life tasks of an individual, as DeNeve and Cooper (1998) argue, locate wellbeing in a deeper relation to the beliefs, emotions, and behaviour that individuals display. This is further developed in relation to models within the salutogenic orientation; here the work of Antonovsky, Adams, Bezner, and Steinhardt (1997), Stumpfer (1995), Coetzee and Cilliers (2001), Wissing and Van Eerden (2002) and Keyes (2002) are discussed.

6.1.11. The salutogenic orientation.

Salutogenic models offer an integrated screening philosophy of wellbeing with a focus falling on developing supportive strategies for wellness. Antonovsky[13] coined the term

[13] Aaron Antonovsky PhD (1923-1994) was an Israeli American sociologist and academic whose work concerned the relationship between stress, health, and wellbeing (Wikipedia.com).

"salutogenesis", which literally means 'health causing'. The term describes an approach which focuses on factors that *support* human health and wellbeing rather than on factors that cause disease. In trying to answer the question of why people stay healthy, he developed what was to become the new paradigm of salutogenesis, meaning the origin of health.

Further, the salutogenic model is concerned with the relationship between health, stress, and coping (Antonovsky, 1984, 1988; 1990). Antonovsky rejected the traditional biomedical dichotomy which separates health and illness, describing the relationship as a continuous variable (seen in the work of Dunn(1959) and Travis(1975), discussed earlier), as a '*health-ease* versus *dis-ease* continuum' (as cited by Becker, Glascoff & Felts, 2010 pp.25-32).

Wellness is widely recognised as the conceptual anchor of a salutogenic orientation, as demonstrated by Travis (1988), yet much emphasis is placed on the detection, measurement, treatment, and prevention of disease, which may in part be due to the enormous array of measurement tools (such as blood pressure equipment) which are only capable of detecting disease risk factors, or the lack thereof. It was the contention of Adams et al. (1997)[14] that by measuring wellness *perceptions*, which often precede observable symptomology, practitioners and researchers could focus on the salutogenic 'pole' – a vertical movement between illness and wellness, and the horizontal movement being a dynamic, balance-seeking force along each dimension of wellness.

Between the two poles are innumerable combinations of wellness in several dimensions and the various states of balance among them, with movement along each continuum, influenced by the movement in all other dimensions. For example, in extreme wellness conditions, one or more dimensions expand and place an 'outward wellness force' on each of the other dimensions. In contrast, in extreme illness conditions, one or more dimensions contract and cause either compensatory or concomitant change in each of the other dimensions (Adams et al., 1977).

It is the view of Coetzee and Cilliers (2001) that the criteria for psychological wellbeing and the criteria for psychopathology are to a great extent independent, and that wellbeing and pathology are not just the endpoints of the same continuum – the absence of psychopathology does not necessarily indicate wellbeing or the presence of psychological strengths. This resonates strongly with the author's views on well*being*. Conversely, low scores on measures of wellbeing or psychological strengths do not necessarily indicate pathology. Thus the view that perceived wellness is a multidimensional, salutogenic construct, which should be conceptualised, measured, and interpreted, is consistent with an integrated view of wellbeing that the author's philosophy seeks to create. Models within the salutogenic origin also highlight that pathology must first be dealt with in any screening philosophy dealing with wellbeing, as it opens avenues in which to help the patient into routes towards adopting salutogenic supportive strategies.

Fortigenesis – the work of Stumpfer.

Yet, the salutogenic orientation towards wellbeing emphasis on supportive strategies remained rather obscure on what it deemed to be *supportive* strategies. Strumpfer (1995) argued that the salutogenic paradigm should be broadened to include sources of strength in response to this. He called this broadening, *fortigenesis*, meaning the *origin of strengths*; a view he deemed to be more embracing and holistic than salutogenesis. Strumpfer (1995) then identified six constructs of fortigenesis to conceptualise aspects of psychological

[14] The work of Adams et al. (1977) is discussed in greater detail later in this chapter.

wellbeing (as cited by Coetzee & Cilliers, 2001). Research carried out by Kossuth (1998) and Viviers and Cilliers (1999) indicates that these constructs are highly correlated.

These constructs, which can be measured empirically, of which the first is a *Sense of Coherence* (SOC). Antonovsky (1987) defined SOC as a global construct that expresses the extent to which one has a pervasive, enduring feeling of confidence that the internal and external environments are predictable, and further, that there is a high probability that things will work out as well as can be reasonably expected – a sense of optimism. These beliefs resound with the components of the coping, social and creative selves such as trust, love, self-control, and patience, that is, positive beliefs and emotions as discussed earlier. With an SOC, the individual will perceive the stimuli from the external and internal environments as structured and predictable (comprehensibility), and perceive that resources are available to meet the demands posed by these stimuli (manageability), and that these demands are challenges worthwhile spending time and energy on (meaningfulness) (Coetzee & Cilliers, 2001).

The second construct deemed to be *Locus of Control* determines the extent to which individuals believe that their behaviour has a direct impact on events that follow, in other words, being self-directed, as noted by Sweeney and Myers (2003) in their Indivisible Self (IS-Wel) model. Individuals who believe they can control events are deemed to have an internal locus of control, and those who blame luck, fate, other people, etcetera have an external locus of control (Rotter, 1966).

The best known measure for this is the Internal External Control Scale (Rotter, 1966), along with the Locus of Control Questionnaire (LCQ) (Schepers, 1995), which is commonly used in South Africa due to its psychometric qualities. The LCQ comprises three scales: external control, internal control, and autonomy. An important difference between the Rotter scale and the LCQ is that Rotter (1966) viewed internal and external locus of control as dependent variables on a continuum, while Schepers (1995) does not view them as opposites, but rather independent variables, and therefore it is conceivable for one to achieve a high score on external as well as internal control for this questionnaire. This would not be case on the Rotter (1966) scale.

Self-efficacy, on the other hand, is based upon the individual's belief in themselves as possessing the necessary resources to successfully perform appropriate behaviour required for a specific task. As postulated by Banda (1982), self-efficacy is a relatively enduring set of beliefs that one possesses the ability to cope effectively in various circumstances. The degree of self-efficacy determines what activities people engage in, how much effort they will expend, and how long they will persevere in the face of adversity (Coetzee & Cilliers, 2001). This construct can be measured with the Self-Efficacy Scale (Sherer & Maddux, 1982) (for general self-efficacy beliefs) and the Eight-Item Self-Efficacy Scale (Thoms, Moore & Scott, 1996) which measures self-efficacy beliefs for a specific task or situation (generally, but not limited to the I-O field in psychology).

The construct *hardiness* evolved from literature regarding stress and coping, and is used to explain individual differences in stress resiliency (Kobasa, Maddi, & Kahn, 1982). Hardiness can be viewed as a style of personality comprising three factors which are intertwined: *commitment* (individuals who involve themselves in whatever they are doing), *control* (individuals who believe and act as if they can influence the events shaping their lives), and *challenge* (individuals who consider change not only as a threat, but also as an opportunity for development) (Coetzee & Cilliers, 2001). Hardiness is measured using the 50-item Personal Views Survey (Kobasa et al., 1982).

Potency is a further construct that is a direct reference to systems theory, in that systems are self-correcting and strive for homeostasis or equilibrium (Heylighen & Joslyn, 1992). As applied to the individual, it means that where the resources are inadequate for meeting certain demands, it causes tension (disturbances in homeostasis) and potency enables the individual to restore homeostasis. If potency is lacking, this tension escalates into lasting stress. Thus, potency is one's enduring confidence in one's own capacities (in having learnt from past coping experiences) as well as confidence in, and commitment to, the social environment or context (Ben-Sira, 1985). Thus, the body is a self-healing system that restores itself in a state of relaxation.

Here, potency elucidates the fact that coping must be viewed as a product of interaction between the person and the environment or context, and this environment is orderly and meaningful. Potency can be measured with the Potency Scale (Ben-Sira, 1985). This scale comprises 19 items measuring *inter alia* self-confidence, mastery, and commitment to society, as well as the perceived meaningfulness and orderliness of society.

Learned resourcefulness is a construct that can be seen to be directly linked to the learning models of psychology. Learned resourcefulness refers to a set of learned behaviours and skills which one uses to self-regulate or control one's behaviour. One can also see the influence of systems theory here (Heylighen & Joslyn, 1992). Learned resourcefulness is a product of one's personality, and includes three functions, namely regressive self-control, reformative self-control, and experiential self-control (Rosenbaum, 1990). Regressive self-control helps one to regulate internal responses (emotions and cognition) that interfere with the smooth execution of an ongoing task, while reformative self-control enables one to change or modify existing behaviour with the view to achieving more successful outcomes. One can do this by using planning skills, problem-solving strategies, and delaying immediate gratification (Rosenbaum, 1990; Coetzee & Cilliers, 2001).

According to Coetzee and Cilliers (2001), experiential self-control enables one to experience and enjoy previously unknown and pleasurable activities to the fullest, which is also described in Goswami's (1995) work. Learned resourcefulness is measured by the Self-Control Schedule (SCS). This scale comprises 36 items that cover the use of cognition and self-instruction to cope with emotional and physiological responses, the application of problem-solving strategies, the ability to delay immediate gratification, and a general belief in one's ability to self-regulate internal events (Rosenbaum, 1990; Coetzee & Cilliers, 2001).

In this sense, Strumpfer's constructs of strengths in fortigenesis illustrate clear links between a person's beliefs and perceptions effect the emotions and behaviours that people exhibit. This understanding resounds with the work of Myers, Sweeney, and Whitmer's Indivisible Self model.

Coetzee and Cilliers, and Wissing and van Eerdan: Moving to psychofortology.

In their research into fortigenesis, Coetzee and Cilliers (2001) include the constructs of constructive thinking, satisfaction with life, emotional intelligence, reality orientation, self-actualisation, resilience, toughness, coping, social support, dispositional optimism, personal causation, self-directedness, social interest, and sense of humour as relating to the maintenance and enhancement of psychological wellness. All of these constructs show some kind of conceptual resemblance to the six constructs defined in the previous section (3.3.4.1).

However, Wissing and Van Eerden (1997) have argued that the focus should not only fall on psychological strengths, as implied by the names salutogenesis and fortigenesis, but also the nature, dynamics, and enhancement of psychological wellbeing. Wissing and Van

Eeden (1997) suggest the term *psychofortology* (i.e., the science of psychological strengths) as a sub-discipline within the domain of psychology in which psychological wellbeing is studied. They posit that a better understanding of psychological strengths will point to new directions for capacity building, and the prevention and enhancement of the quality of life of individuals (as cited by Coetzee & Cilliers, 2001)[15].

Criticisms of Salutogenesis, fortugenesis and psychofortology.

While there has been much praise for advocating salutigonesis and sense of coherence, criticism has been launched in regard to its individualistic approaches and explanations (Harrop, Addis, Elliott, & Williams, 2006). While Antonovsky's (1998) approach stresses resilience, the concept implicates that it is accessible only to individuals with privileged positions, as people in poverty can often have limited control over their surroundings and relationships (Harrop et al., 2006). Furthermore, sense of coherence is often portrayed as being embodied only by individuals, which Antonovsky (1998) claims is erroneous, on the grounds that it can be a collective attribute as well. In response to this explication of the concept, it needs to be incorporated in the broader social network while a more operationalised definition is needed to identify it (Harrop et al,2006)

While these criticisms are valid, salutogenesis, fortugenesis, and psychofortology embody a move towards understanding wellbeing or wellness as a form of balance and the perception of individuals in what they believe about themselves, how they feel, and what actions they commit, that is, their virtues. This understanding of wellbeing based on strength and perception also allows for a dynamic model that is based upon leading the client towards strength, which is useful for an integrated wellbeing philosophy. Furthermore, the link to perception is an important one, especially regarding the links between thoughts, feelings, and behaviour. As Adams et al. (1997) have noted, this led to their creation of The Perceived Wellness Survey (PWS), which prioritises the role of perception and belief in wellness.

6.1.12. The Perceived Wellness Survey (PWS) –(Adams et al. 1997).

Introduction.

Adams et al. (1997) were initially influenced by the work of Wilson and Cleary (1995), who integrated several components including biological and physiological variables according to one's perceptions, into their view of health. They stated that these "represent an integration of... health concepts. They are among the best predictors of the use of general medical and mental health services" (p. 62).

Thus, how one views the world, that is one's perceptions, powerfully influences one's health and wellbeing. Perceptions or beliefs about one's health have been identified as one of the strongest predictors of physical and mental health care utilisation (Stewart, Hays, & Ware, 1992). Thus, while the influence of standard risk factors cannot be ignored, individual perceptions are also important because they may actually precede overt manifestation of illness or wellness and may therefore be fertile ground for early intervention or enduring celebration respectively[16]. The author acknowledges that individuals process and interpret information from various sources in many different ways – that is, from a cognitive

[15] It is noteworthy that much psychofortology research has been conducted in South Africa, Israel, Europe, and the United States, albeit only in the field of Industrial and Organisational psychology.

[16] This is noted in Quantum Physics where individual perceptions and consciousness are inextricably linked within a tangled hierarchy (as discussed in Chapter 3).

behavioural approach and the information processing approach[17]. Therefore, Adams et al. (1997) proposed a study of wellness in which they examined how wellness perceptions would fit into an overall model as a positive contribution to the field of wellbeing.

At that time, a longstanding tradition had existed in the empirical study of perceptions, inter alia, those of Cohen, Sherrod, and Clark (1988), Cohen and Wills (1985), Procidano and Heller (1983), Procidano (1992), and Wethington and Kessler (1986). Concomitantly, there was much research into the topic of the times, that is stress and its effects on behaviour and wellness. Here one can note that the findings of the research carried out by Antonovsky (1984, 1988), Kobasa (1979), and Selye (1974) are very similar to Rankin's (2013) explanation of stress-response and emotions[18].

Adams et al. (1997) were also influenced by epidemiological research, noting that self-rated perceptions of health are among the most powerful predictors of subsequent health outcomes and in turn the importance of beliefs (Fylkesnes & Forde, 1991; Idler & Angel, 1990; Idler & Kasl, 1991; Kaplan & Camacho, 1983; Mossey & Shapiro, 1982; Singer, Garfinkel, Cohen, & Srole, 1976; Stewart, Hays, & Ware, 1992).

As will be evident, Adams et al. (1977) were also influenced by the increasing pervasiveness of systems theory, as discussed previously. They used Dunn's (1961) theory of high-level wellness (i.e., individual wellness involves an integrated method of functioning) as a philosophical foundation on which to build their model, noting that at the individual level wellness implies multiple, simultaneous functioning at various levels within the body, comprising the physical, spiritual, psychological, social, emotional, and intellectual dimensions (Crose, Gobble, & Frank, 1992; Greenberg, 1985; Nicholas, Gobble, Crose, & Frank, 1992; Seeman, Whitmer, & Sweeney, 1992). To reiterate, Dunn (1961:2) defined wellness as being "oriented toward maximising the potential of which the individual is capable"[19]. The PWS thus sees that the understandings or beliefs that people perceive about their own emotional, behavioural, and environmental states, influence their wellbeing.

Furthermore, Adams et al. (1977) note that models of wellness should include several dimensions which should be operationalised and interpreted consistent with the systems approach. Specifically, the wellness magnitude within each dimension and the balance among them should be simultaneously considered. Further, these authors, like Jasnoski and Schwartz (1985), say that a valid wellness model should either include cultural, organisational and environmental factors, or be connectable to models that include these factors. This is a noteworthy statement in that Adams et al. (1977) state that *either* cultural, organisational, or environmental factors should be considered; thus in their opinion not all are necessary. Witmer and Sweeney (1992) and Myers et al. (2000) clearly note the importance of work on wellness (as did Strumpfer, 1995) also supports Antonovsky's (1998) finding that specific work experiences strengthen salutogenic functioning. The consistency between all these wellness researchers on what strategies of wellbeing should consider, is important, as it identifies a common thread running through all their wellness research The

[17] The author concurs with Wilson and Cleary (1995) and Adams et al. (1997) that this variation can be viewed as either controllable or uncontrollable, residual error being due to individual differences, and for the psychologist serves as a rich amount of information about influences on wellbeing

[18]The work of Antonovsky is particularly important, as he influenced South African researchers of wellness, as discussed in the previous section.

[19] Thus clearly a self-directed approach that reflects the notes of Goswami (2011) and Quantum Physics on downward causation.

present author can draw upon the aforesaid in developing the philosophy's note on environmental factors.

The PWS model.

Building on the notion that practitioners rely heavily on clinical, physiological, and behavioural measures to plan interventions and to predict various health outcomes, while they are valuable indicators of bodily health, they provide little information about the wellness of the mind (Adams et al., 1977). Noting that perceptual measures have been used to predict a variety of health outcomes effectively (Idler & Kasl, 1991; Mossey & Shapiro, 1982; Stewart et al., 1992; Eysenck, 1993), Adams et al. (1977) posit that valid perceptual measures could complement body-centred indicators of wellness, thus providing both researchers and practitioners with important information.

Wellness-related, perceptual constructs include psychological wellbeing (Bradburn, 1969; Reker & Wong, 1984; Ryff, 1989), mental wellbeing (Jahoda, 1958; Taylor & Brown, 1988), subjective wellbeing (Andrews & Robinson, 1991; Diener, 1984; Kammann & Flett, 1983), general wellbeing (Campbell, Converse, & Rodgers, 1976; Fazio, 1977), morale (Lawton, Morris, & Sherwood, 1975), happiness (Fordyce, 1986; Kozma & Stones, 1980), life satisfaction (Diener, Emmons, Larsen, & Griffin, 1984; Neugarten, Havighurst, & Tobin, 1961) and hardiness (Williams, Wiebe, & Smith, 1992; Kobasa, 1979).

Based on their view of wellness-related constructs, Adams et al. (1997) developed their measure of perceived wellness, that is, the Perceived Wellness Survey. They included what they note as the six dimensions of wellness: physical, spiritual, psychological, social, emotional, and intellectual, which compromise the various aspects of an individual's social realm.

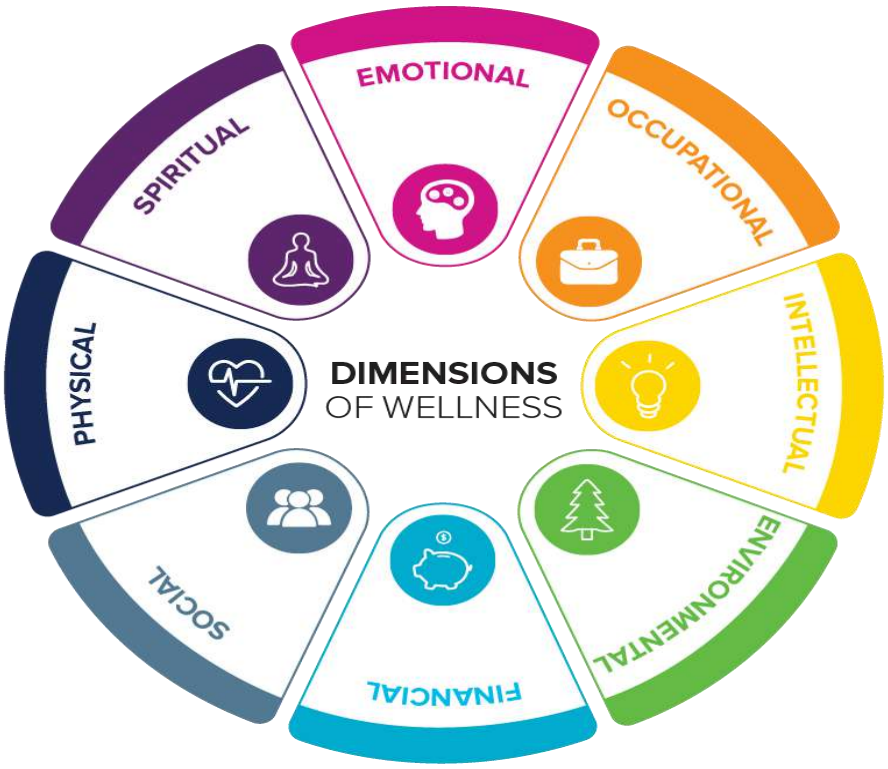


***Figure 6.7*: The PWS Model (adapted from Rothmann,S et al 2007 p36)**

A factor analysis (.85) confirmed the appropriateness of these dimensions, thus validating expectations that it is a unidimensional scale. Sample items from each dimension are respectively, 'I expect to always be physically healthy', 'I believe there is a real purpose for my life', 'In the past, I have expected the best', 'My friends will be there for me when I need help', 'In general, I feel confident about my abilities', and 'In the past, I have generally found intellectual challenges to be vital to my overall well-being'. These bear great insight into the role of virtues discussed in the author's integrated wellbeing philosophy (see Chapter 5).

However, this does not suggest that wellness is a unidimensional phenomenon, but only that perceptions of wellness in hypothetical dimensions are related more so by their perceptual nature than they are differentiated by their content. The authors point out that in their initial research, the strongest loading items (>=.50), share only three common themes: 1) purpose in life, 2) optimism, and 3) self-esteem, strongly suggesting that the Perceived Wellness Survey is an effective construct. This links purpose, optimism, and self-esteem as attitudes or behaviours which resonate strongly with the positive virtues that people may hold.

The PWS has been tested empirically for over twenty years, further confirming that wellness is an integrated, multi-aspect phenomenon, and that one's perceptions have a powerful (and sometimes negative) effect on one's health and wellbeing (Bezner & Hunter, 2001; Dolbier, Soderstrom, & Steinhardt 2001; Ketz & Israel, 2002; Kinney, Rodgers, Nash, & Bray, 2003; Carter, 2004; Tsai Cheng-Yu, 2004; Harari, Waehler, & Rogers, 2005; Jewell, 2005; Sidman et al. 2009

The PWS, in the significance it places upon perception, illustrates that the connections between the beliefs that individuals hold concerning their wellness can influence their emotional and behavioural states. In turn, it stresses the need to closely examine more fully what the term mental health encompasses and its connection with wellness. To examine this, the author refers to Keyes' notion of a complete state of mental health.

6.1.13. Keyes' Complete state of mental health.

The views that Keyes (2005, 2010) holds on wellbeing are very much concerned with aspects of social, psychological, and emotional wellbeing. He states that "mental health is a *complete state* and not merely the absence of mental illness symptoms or diagnoses" (Author's italics), and the goal of any approach should be twofold: a reduction of mental illness, and the promotion of rates of complete mental health (2010)[20].

In order to achieve this goal, Keyes (2010) proposed a model of wellbeing in response to both biomedical and salutogenic understandings — the complete state model. The model is premised on the conception of a whole healthy being, best exemplified in the WHO's (1948) definition of overall health as comprising the presence of positive human capacities and functioning as well as the absence of disease or infirmity.

In his model, Keyes (2002; 2010) viewed wellbeing as a continuum that, like mental illness, mental health is an emergent condition, based on the concept of a syndrome. In turn, he operationalised mental health as a syndrome of symptoms of positive feelings and positive functioning in life (Keyes, 2002). Keyes (2002) describes a diagnosis of the presence of mental health as *flourishing*, and the absence of mental health at the other end of the

[20] Although Keyes (2002, 2005) uses the term 'mental health' in his earlier work, in the author's opinion, he is in fact referring to wellness (he used the term wellbeing in his later works in 2010) as he was influenced by the work of Antonovsky.

continuum, as *languishing.* Thus, a complete state of health (in other words, wellbeing), like illness, is indicated when a set of symptoms at a specific level are present for a specified duration, and this constellation of symptoms coincides with distinctive cognitive and social functioning (Mechanic 1999, Keyes 2002, 2010).

To support his understanding of wellbeing, using several scales, Keyes (2002) sets out to establish the prevalence of languishing or flourishing in his sample of adults. The first of these, *mental illness,* was measured using the Composite International Diagnostic Interview Short Form (CIDI-SF) scales (Kessler et al., 1998) as they demonstrated excellent diagnostic sensitivity and specificity when compared with diagnoses based on the complete CIDI in the National Comorbidity Study (Kessler et al., 1999). This scale was used to assess whether respondents had exhibited symptoms indicative of a major depression episode during the past 12 months (based on the criteria established by the DSM-III-R – APA, 1987).

To examine the individual's level of *emotional wellbeing,* a self-administered questionnaire was used to evaluate six symptoms of positive affect: (1) cheerful, (2) in good spirits, (3) extremely happy, (4) calm and peaceful, (5) satisfied, and (6) full of life, as well as their life satisfaction, measured on a Likert scale of 0-10. The internal reliability of the positive affect scale is .91 (Mroczek & Kolarz, 1998).

Psychological well-being was investigated through Ryff's (1989) measures of psychological wellbeing, which operationalised the extent to which individuals see themselves thriving in their personal life. These measures represent distinctive dimensions (Ryff & Keyes 1995) of subjective wellbeing: *self-acceptance* ('I like most parts of my personality'), *positive relations with others* ('Maintaining close relationships has been difficult and frustrating for me'), *personal growth* ('For me, life has been a continual process of learning, changing, and growth'), *purpose in life* ('I sometimes feel as if I've done all there is to do in life'), *environmental mastery* ('I am good at managing the responsibilities of daily life'), and *autonomy* ('I tend to be influenced by people with strong opinions'). Respondents answered in terms of a Likert scale of 1-7 indicating the extent to which they agreed or disagreed with the statement.

Keyes' (1998) measures of social well-being operationalised the extent to which individuals view themselves as thriving in their social life. Here the following were measured: *social acceptance* ('People do not care about other peoples' problems'), *social actualisation* ('Society isn't improving for people like me'), *social contribution* ('My daily activities do not create anything worthwhile for my community'), *social coherence* ('I cannot make sense of what's going on in the world'), and *social integration* ('I feel close to other people in my community').

In their research, multivariate analyses revealed that languishing and depression were associated with significant psychosocial impairment in terms of perceived emotional health, limitations of activities of daily living, and workdays lost, while flourishing and moderate mental health were associated with superior profiles of psychosocial functioning (Keyes, 2002). This led Keyes to provide a comprehensive overview of what he deems to be a categorical diagnosis of mental health (in other words, optimal wellbeing), requiring high scores on two aspects, *hedonia* and *positive functioning*. In Keyes' view (2002, 2005, 2010), if an individual has high scores on these two diagnostic criteria, they can be considered to be flourishing.

Keyes (2010) notes that both social and psychological scientists have been studying positivity in the domain of subjective wellbeing (individuals' evaluations and judgment of their own lives) for over 50 years, leading to 13 specific dimensions of subjective wellbeing in the

U.S. adult and adolescent populations. According to Keyes (2005, 2010), research has shown that the scales measuring subjective wellbeing represent positive emotions towards one's life (*hedonic well-being*) and positive functioning in life (*eudaimonic wellbeing*). The symptom descriptions for the two diagnostic criteria for wellbeing are presented in Table 3.2 below:

Table 6.4
Keyes (2005) categorical diagnosis of wellbeing (flourishing) pp. 207

Diagnostic criteria	Symptom description
Hedonia: requires high level on at least one symptom scale (Symptoms 1 or 2)	1. Regularly cheerful, in good spirits, happy, calm and peaceful, satisfied, and full of life (*positive affect past 30 days*)
	2. Feels happy or satisfied with life overall or domains of life (*avowed happiness or avowed life satisfaction*)[a]
Positive functioning: requires high level on six or more symptom scales (Symptoms 3–13)	3. Holds positive attitudes toward oneself and past life and concedes and accepts varied aspects of self (*self-acceptance*)
	4. Has positive attitude toward others while acknowledging and accepting people's differences and complexity (*social acceptance*)
	5. Shows insight into own potential, sense of development, and open to new and challenging experiences (*personal growth*)
	6. Believes that people, social groups, and society have potential and can evolve or grow positively (*social actualization*)
	7. Holds goals and beliefs that affirm sense of direction in life and feels that life has a purpose and meaning (*purpose in life*)
	8. Feels that one's life is useful to society and the output of his or her own activities are valued by or valuable to others (*social contribution*)
	9. Exhibits capability to manage complex environment, and can choose or manage and mold environments to suit needs (*environmental mastery*)
	10. Interested in society or social life; feels society and culture are intelligible, somewhat logical, predictable, and meaningful (*social coherence*)
	11. Exhibits self-direction that is often guided by his or her own socially accepted and conventional internal standards and resists unsavory social pressures (*autonomy*)
	12. Has warm, satisfying, trusting personal relationships and is capable of empathy and intimacy (*positive relations with others*)
	13. Has a sense of belonging to a community and derives comfort and support from community (*social integration*)

[a] Life domains may include employment and marriage or close interpersonal relationship (e.g., parenting).

6.1.14. Wellness behaviour and characteristic inventory (BMS-WBCI).

In 2006, Hey et al. set out to develop a Wellness Behaviour and Characteristic Inventory (BMS-WBCI) using the mind, body, and spirit dimensions of wellness. The purpose was to measure wellness behaviours and characteristics, initially only for college students. As these authors noted, at that time a slew of instruments to assess wellness were available, not without their various limitations, but to gain a complete picture of wellness (i.e., emotional, mental, physical and spiritual health), multiple instruments had to be used (Hey et al., 2006). Further, using multiple instruments is time consuming and tiring for both the analyst and the participant.

For example, Adams, Bezner, Drabbs, Zambarano, and Steinhardt (1999) had to use several instruments to measure the three constructs of spiritual, psychological, and perceived wellness in their research. These authors used the Life Attitude Profile (Recker & Peacock, 1981), the Life Orientation Test (Scheier & Carver, 1985), Sense of Coherence Scale (Antonovsky, 1988), and the Perceived Wellness Survey (PWS) (Adams et al., 1997). Similarly, Bates, Cooper,2001) in their study examining college student wellness, used three surveys: the Salubrious Lifestyle Scale of the Student Development Task and Lifestyle Assessment (Winston, Miller, & Cooper, 1999), the CORE Alcohol and Drug Survey (Presley, Harrold, Scouten, Lyerla, & Meilman, 1993), and the Physical Activity and Nutrition subscales of the Health Promoting Lifestyle Profile-II (Walker, Sechrist, & Pender, 1987). The purpose of this research was to merely assess behaviours related to alcohol and drug use, nutrition, and exercise among college students (Bates et al., 2001).

Although all these instruments measure important aspects of wellness such as physical activity, nutrition, and drug and alcohol behaviour, according to Hey et al. (2006), the combination of these instruments still failed to measure mental and spiritual aspects of wellness. This indicated that even when multiple assessment instruments are used, important aspects of wellness may be overlooked, which prompted the work of Hey et al. (2006).

The first part of their study comprised a factor structure for the Body, Mind and Spirit Scales using principal components analysis. In an item generation and factor analysis using 1 000 college students, this resulted in average loadings of .64, .51, and .58 for the Spirit, Mind, and Body factors, respectively. All three scales were positively correlated.

The second study phase included validity testing using *inter alia* Test Well (based on Hettler's six dimensions of wellness, as discussed previously). Hey et al. (2006), in a major criticism of the TestWell measure, state that the content lacks validity and clarity about whether attitudes, behaviours, or knowledge are being measured. However, they note that the BMS-WBCI dimensions yielded high, positive correlations for all the appropriate TestWell subscales.

This resulted in a revised 44-item Body-Mind-Spirit Wellness Behaviour and Characteristic Inventory (BMS-WBCI), using a 3-point Likert scale (1. *rarely/seldom*, 2. *occasionally/sometimes*, & 3. *often/always*). Examples of statements from the BMS-WBCI include the following: "I surround myself with physically healthy people" (Body); "I am open to new ideas" (Mind); "I experience harmony within" (Spirit). The raw scores obtained from the inventories were categorised into three ranges: 44-73 stipulated that the respondent needed immediate behaviour change to improve wellness lifestyle; 74-103 indicated that the respondent was on the way to a wellness lifestyle, but behaviour change is needed in certain areas; while 104-132 showed that the frequency of behaviours indicates the existence of a healthy lifestyle.

The BMS-WBCI represents a model of wellbeing which explicitly links the role of the mind, spirit, and body in wellbeing. The model of Hey et al. (2006) addresses the problem of using multiple measures for wellbeing and that integrative, simple models are needed to address this issue. For the present author, the model represents a great leap towards an integrative understanding of wellbeing, but the use of convenience sampling in creating the inventory is a serious limitation. However, some research has been carried out yielding noteworthy

results in regard to its reliability and correlation with other wellness constructs and other population samples[21].

Moreover, while the said model represents a connection between a person's mind, spirit, and body, it does not explicitly deal with the relation between beliefs, emotions, and behaviour. In this sense, while it assimilates understandings from previous models, it does not address the rich interplay between thoughts, feelings, and actions in wellbeing; it only alludes towards it. This then calls for an integrated philosophy which can not only draw upon the understanding of previous models regarding the interconnection between mind, body, and spirit, but also underscores this philosophy with a conceptualisation that can apply to earlier models as well.

6.1.15. Integration of contemporary wellness or wellbeing models.

The author has briefly discussed the numerous times that similar constructions of wellbeing have appeared throughout the literature on models of wellness. Considering this to be an avenue in which to aid the construction of an integrative screening method, as well as drawing on grounded-theory methodology, the author presents an initial table (see Figure 6.8), which codifies these similarities in previous wellness models constructs.

***Figure 6.7*: Synethesis of wellbeing undestandings**

The author has used the five dimensions of the indivisible self in the IS-WEL to categorise the similarities between the constructs in response to the amount of empirical research conducted on this model and its understanding of wellness. As evident in the table, several

[21] For further research, refer to Khalil's (2008) study on hardiness and the study conducted by Mareno and James (2010) regarding the reliability of the BMS-WBCI.

constructs in certain models apply to more than one category of "self". Furthermore, the last row indicates constructs, which correspond with all the models of wellbeing.

For example, the first category of the "Creative Self" in the IS-WEL runs parallel with the understanding of the category of the "mind" and the "intellectual" in the BMS-WBCI and PWS, thus underscoring a person's wellbeing. Furthermore, these understandings also link to how the WEL views *problem-solving and creativity*, as well as *realistic beliefs* role in well-being. The author views the constructs of *love, trust*, and *self-control* as informing how these aspects of wellbeing are defined.

This is most explicitly seen in focus of the creative self on the "attributes each of us forms to make a unique place among others in our social interactions and to positively interpret our world" Myers, J.E., Sweeney T.J 2004 pp. 238 with the BMS-WBCI, which sees the mind directly affecting how one perceives the world. This is seen in one the statements on the inventory: "I am open to new ideas", which links to positive interpretations of the world. Similarly, the WEL's construct of *problem-solving and creativity* resembles a similar idea that positive, trusting beliefs and behaviours are evidenced in people who are closer to well-being than dis-ease.

Upon further reflection of the figure above (Figure 3.8) the construct of love resounds with each category of similarities across the models. This reflects current research in the Grant study (Vaillant, 2012), which evidenced that happiness is love. The author finds this an invaluable way to guide the creation of an integrative wellbeing philosophy, as the virtue of *love* resounds with all the models of wellbeing that are discussed in this study. The idea of virtues also provides a useful link to comprehending how beliefs, emotions, and behaviour can interact with each other, especially when looking towards psychological perspectives and quantum physics, which the author explores in the next chapter.

6.2. Conclusion

In reviewing the models of wellbeing, the author has noted that there is a similar understanding among them regarding the beliefs, behaviours, and emotions that a person demonstrates and which are considered to be evidence of a person's wellbeing. In exploring this in relation to the models, many have emphasised that these constructs are inextricably intertwined, because the manner in which a person perceives their wellbeing is seen to affect their emotional state, and in turn, the actions they exhibit as presented in the PWS. The author furthers this notion, preferring the idea of virtues which offers a similar understanding, yet greater clarity on how a person's perception or beliefs affects their emotional and behavioural states of wellbeing.

The review of earlier models of wellbeing has also emphasised that a wellbeing philosophy must be able to encompass all aspects that have been seen to relate to wellbeing without the resultant model being exhaustively long. Moreover, it has also stipulated that the philosophy must incorporate measures to assess the person's presenting state of wellbeing before moving on to fully measuring wellbeing, as seen in Hindler's model where immediate stressors can affect the degree to which clients can be led to facilitating their own wellbeing.

These models have also emphasised the necessity to base the method on the idea of wellbeing as a dynamic and changeable concept, which lies within the hands of the client and not the counsellor. An effective integrative philosophy will have to be formulated on the premise of directing clients towards facilitating their own wellbeing, and be explicit in how patient-responsibility is understood so as not to appropriate blame (Tuohima, n.d.).

However, greater clarity is needed in developing this model in relation to its ability to be used with mood and anxiety disorders as well as how the conception of virtues can be used to clarify the connection between mind, body, and soul. The author discusses this in the following chapter of the literature review.

Chapter 7
Results and Discussions of Virtue-based Well-being

7.1. Introduction

This chapter discusses the preliminary research carried out while developing, testing and implementing an integrated wellbeing philosophy for the wellness counselling profession. It thus deals with the research questions in developing the philosophy itself, wherein counsellors were asked to prepare positive and negative statements of what would evidence the nine virtues upon which the screening philosophy is based. Here, the researcher discusses the general views held by the counsellors in their understanding of virtues and utilises these understandings to develop the virtue-based model of wellbeing that underpins the philosophy.

The subsequent research discussed herein is a comparison between the Personality Assessment Inventory-2 (PAI-2) and the author's Wellbeing Questionnaire (WQ). This section revolves around the research questions: Does a virtues-based philosophy correlate with previous understandings and measures of wellness/wellbeing, and associations with measures of mental health. Thus, this section attempts to pilot initial investigations into using the WQ philosophy to aid counsellors in diagnosing mood and anxiety disorders.

The author presents two case studies taken from his initial research into the use of WQ in screening, with the therapeutic interventions based at his own practice. These two cases are selected to illustrate the potential benefits that a virtue-based screening philosophy could have for the counselling profession, and in turn, generate further possible research into this area. It is important to note once again that this dissertation is a pilot project to investigate the potential that virtues may hold in helping counsellors and their clients towards wellbeing. Thus, the associations listed and discussed do not prove causation, but rather, possibilities for wellbeing. With this in mind, the author turns to the first set of studies that focus on counsellor's associations with virtues.

Coding of Counsellors Statements Regarding Virtues

In order to further substantiate the author's Wellbeing Questionnaire (WQ), twenty counsellors were asked to note their understandings of what statements would evidence negative and positive beliefs, behaviours, and emotions which would resound with the author's nine virtues of wellbeing. The following tables represent the initial coding of the said twenty respondents' understandings of virtues, whereafter the author discusses the general trends.

7.1.1 Virtue of love.

When describing their understanding of statements which would evidence positive and negative emotions of love, the counsellors stressed three core themes of unforgiveness versus forgiveness; feelings of insignificance versus feelings of significance; and bitterness versus happiness. These contrasting sets of emotions were parallel to statements made with regard to beliefs and behaviours. The negative emotional statement of 'I feel insignificant' is referenced in the belief statement *I am insignificant*, and in behaviour which counsellors noted they would see as 'self-neglecting'.

Table 0.5
Virtue of love

Virtue	Negative Emotion	Positive Emotion	Negative Beliefs	Positive Beliefs	Negative Behaviour	Positive Behaviour
Love	Unforgiveness Feeling of insignificance and resentment Hostile Self-rejection Love of power Bitterness Aggressiveness Irritation Hate	Contentment Feeling of belonging Forgiveness Significance Compassion and empathy Friendly Light and bubbly Inner happiness Power of love Self-acceptance Open Worthy	I am unlovable I am hated People reject me I am a victim I resent my whole being Anxious I cannot improve Unsuccessful Ugly I am insignificant I am flawed	I am lovable I can love I am passionate I can make it happen I forgive I am accountable I can do anything Successful I am insignificant I am whole I am unique and special	Selfishness Hated and jealous Self sabotage Ugly with people Judgmental Hurtful words Uncommitted Do not trust Self-neglecting	Loving Loving self and committed to the truth Ownership of self Like myself Enjoy my own company Happiness Success Compliments Do not take hurt personally Take responsibility of how I feel Energised and allow others to love me

6.2.1. Virtue of joy,

In comparison with the three core themes identified by counsellors concerning the virtue of love, joy is framed as the antithesis of depression. In the negative behaviour column (Table 7.2), counsellors most frequently referred to the traits of loneliness, withdrawal and being despondent. This starkly contrasts with evidence of joyful behaviours and beliefs that stress a positive outlook on an individual's self and place in society, as well as their engagement with the world as an extremely pleasant experience.

Table 0.6
Virtue of joy

Virtue	Negative Emotion	Positive Emotion	Negative Beliefs	Positive Beliefs	Negative Behaviour	Positive Behaviour
Joy	Sadness Apathy Despair Isolation Mourning Unproductive Depression Lack of energy Feeling inferior Worthless and flawed Pain	Happiness Excitement Enlightenment Astonishment Vibrance Energetic Feel alive Exhilaration Confidence Strength, wholeness and self-worth Playfulness	I am worthless I cannot have fun Joy are not allowed Nobody needs me I am not OK Everything is a lie I am hopeless Life is hopeless Laughter cannot conceal my heavy burden heart I deserve the pain I am feeling every day	I am a person of worth Happiness Positive memories I contribute to self and society I take the good from negative experiences Respect I am valuable and funny My joy is contagious I am a person of worth regardless of any circumstances. I have unbounded hope for the future I take action	Staying alone Loneliness No interest in social networking Withdraw from things Despondent I fool everybody I do not even try to smile	Believing in my power to start each day anew Look after my body, care for my health Schedule pleasant events Engage with the world Positive outlook New challenges Motivated by truth and love in anything I do I permit myself to have fun. I laugh a lot.

7.2.2. Virtue of peace.

Reported understandings of peace are best exemplified in the positive beliefs the counsellors mentioned that their clients would most likely state. These included the respondents who reported that they felt that their future looked positive (*wonderful things are in store for me*) and that their future was not tied to their past. This links with the negative emotions and beliefs that fear and anxiety are prevalent states that the client would report if they did not experience any peace in their life. However, the counsellors saw people with peace reporting behaviours that would show that their relationships with others would be positive and that respondents would create safe and positive environments for themselves (see Table 7.3).

Table 0.7
Virtue of peace

Virtue	Negative Emotion	Positive Emotion	Negative Beliefs	Positive Beliefs	Negative Behaviour	Positive Behaviour
Peace	Worry and fear Disgust Anxiety	Restfulness Compassion Sense of peace. Everything is perfect the way it is and should be.	The future will be like the past There is no inner peace inside me Something bad is going to happen. I am not okay	Wonderful things are in store for me I allow myself to experience peace within my heart and mind My future is not tied to my past I am free I am always okay	Focusing on the bad things in the past I am a failure Destructive memories Worrying about the future	Seeking win/win situations in my relationships. I can create a warm sanctuary for my soul in daily life Focusing on good things that are related to the future Focusing on the present

7.2.3. Virtue of patience.

Patience is observed by counsellors in statements which show that the client is *content to wait for something better and able to wait in peace* for it. This is further evident in beliefs that exhibit that *ease of mind*, or satisfaction of the individual with the present. Similar understandings of the emotions that display patience, such as contentment, fulfilment and empathy show a positive virtue of patience in the person's wellbeing (Table 7.4). Virtue of Patience

	○ **Negative Emotion**	○ **Positive Emotion**	○ **Negative Beliefs**	○ **Positive Beliefs**	○ **Negative Behaviour**	○ **Positive Behaviour**
Patience	○ Nervousness ○ Agitation ○ Despair ○ Blame ○ Sarcasm ○ Ignorance ○ No-motion ○ Frustration ○ Chaos	○ Altruism ○ Respect and care for self and others ○ Contentment ○ Forgiving ○ Teamwork ○ Worthy ○ Uplifted ○ Fulfilment	○ Something has to change right now for me to be okay ○ To wait is not a good option ○ I want action right now ○ Need to get out of this ○ Feeling awkward	○ Even though I'm always growing and learning and getting better, I am satisfied and content right now ○ I will allow time to bring answers and peace ○ Happy place	○ Attempting to change something right now in order to feel secure, satisfied or content ○ Nothing I do, think or feel will have a positive outcome. I am	○ Content to wait for something better and able to wait in peace ○ To patiently wait for the results teaches me the art of good timing ○ Everything happens

	○ Anger ○ Punishment ○ Desire for love substitutes ○ ○ ○	○ Understanding ○ Wisdom ○ Inspiration to understand ○ Satisfaction ○ Security ○ empathy	to reach out to others ○ I will get it somewhere else! ○ Anger is needed to maintain justice and peace ○ ○ ○	○ From here on it only gets better ○ I have ease of mind ○ It gives me reason to faithfully await the positive outcome ○ I desire what is best for me and my family and a will to persist to educate to be patient even if it is hard to keep up	doomed as my whole life confirms ○ Putting blame on others ○ Nothing will ever change, no matter how hard I try. ○ I never go to places where I have to wait. ○ I will not waste personal time on that. ○ I want to get even,	for a reason ○ I know I will succeed ○ Patience brings out the best in me ○ Rewards are always good when I make conscious decision to wait for good opportunities and outcomes ○ Passionate desire to set things right

	no matter what

Table 0.8
Virtue of patience

7.2.4. Virtue of kindness.

While patience is built on satisfaction with the present, the virtue of kindness, for counsellors, can only occur when a person evidences statements that show an absence of ‘hurt’; ‘sorrow’ and ‘self-centredness’. These negative emotional states display links for counsellors in their understanding of the necessity for respondents to believe that they have had loving personal relationships and the belief that emulating these relationships is also rewarding for them. The focus of the personal relationships for counsellors stresses a strong sense of the ‘I’ or ‘self’ within this category (Table 7.5).Virtue of Kindness

Table 0.9
Virtue of kindness

Virtue	Negative Emotion	Positive Emotion	Negative Beliefs	Positive Beliefs	Negative Behaviour	Positive Behaviour
Kindness	Hurt Sorrow Rejection Hurt-resulting in fear I am deprived of hope and love Self-centered Greed-only care for my own needs Emptiness Insensitivity	Total and unconditional acceptance of myself and others Generosity Congruent Tenderness Consideration Salvation	People will take advantage of me, if you have been rejected People are too sensitive, if you are the one who rejects others I am a failure People have hidden agendas I have nothing good to give	I love everyone I have an abundant reservoir of kindness through the examples of my parents and their example of kindness Everyone is different but all have worth and value. I want truth and I want love in my relationships Kindness feeds the soul I have good quality of life	Rejecting others I am never satisfied with the actions of others Dismissive of other people's feelings Nobody wants me as a friend I treat others how I feel like.	Accepting self and others unconditionally I take time to be kind in order to have fulfilment in life I give special consideration for others happiness and development

7.2.5. Virtue of goodness.

Similar to the virtue of kindness, goodness was also established by counsellors as being strongly grounded within relationships, for example, '*I am a team player'* and the inverse, *'I make no contribution towards society'*. Behavioural statements suggested by counsellors corroborated this focus, as negative statements revolved around isolating behaviour and hurting others, while positive ones stressed making a difference as well as excellence in what is done by the individual (at work, at home, etc.) (Table 7.6). Virtue of Goodness

Table 0.10
Virtue of goodness

• Virtue	• Negative Emotion	• Positive Emotion	• Negative Beliefs	• Positive Beliefs	• Negative Behaviour	• Positive Behaviour
Goodness •	• Fear • Shame • Misfortune • Blame • Disbelief • Defiance • Hide behind a mask	• Gratitude • Boosting mental persistence • Thankfulness and gratitude • Prudence • Respect • Admiration • Gracious	• I am too jealous to be happy • I am bad or not good enough. I am unforgiveable • I am wounded by sin • I make no contribution • Why me? •	• I am good, forgive, clean and built for love • I strive to always do good • Discern my true good in every circumstances • I am a team player • I am honourable •	• Believing the lies of faulty programming • I inflict misfortune on others • Whatever I do will have a negative result • I work alone	• Belief the truth about who I am • Goodness is the positive motivational force that I feed on when my daily actions need to make a difference • I choose the right means of achieving it • I am excellent in what I do

7.2.6. Virtue of self-control.

The lack of the virtue of 'self-control' was understood by counsellors to be observed in clients who believed very little in their own capabilities or had little empathy for others. This is perhaps best seen in the negative beliefs: "*I can't do it*"; "*I lack interest*". This is further seen in the negative behaviours that were suggested as being 'judgmental in nature' and manipulative. However, when this virtue is found positively in clients, counsellors believed that a person would demonstrate confidence and assertiveness in all aspects of their life (Table 7.7). Virtue of Self-Control

Table 0.11
Virtue of self-control

Virtue	Negative Emotion	Positive Emotion	Negative Beliefs	Positive Beliefs	Negative Behaviour	Positive Behaviour
Self-control	Laziness Entitlement Helplessness Powerlessness Detachment Judgmental Clumsiness Complacency Avoidance Helplessness	Confidence in my true self and in my capabilities Assertiveness Freedom Courage Awareness Self-motivated Tenaciousness Commitment Wisdom Education	I can't do it. I am not capable, others should do it for me and it is not fair Lack of interest Criticize others	I am capable. I can do it. Others don't need to do it for me. I have a say over my life Dynamic Self-pride Courage I can manage my emotions	Manipulation Deceit Giving up Vulnerable Insensitive Arrogant	Positive actions powered by love and my calling in life successful

7.2.7. Virtue of trust.

Trust as a virtue, for counsellors, lay within two beliefs that an individual would express; these could be labelled as either ‘cynical’ or ‘idealistic’. For the counsellors, they understood a person with ‘trust’ to express feelings of ‘mindfulness’; ‘awareness’, ‘commitment and loyalty’ and ‘perseverance’ in their lives. On the negative side, the counsellors suggested that a person who did not score high on the virtue of trust would state that they were skeptical about their lives and have little faith in other people’s abilities (Table 7.8).Virtue of Trust

Table 0.12
Virtue of trust

Virtue	Negative Emotion	Positive Emotion	Negative Beliefs	Positive Beliefs	Negative Behaviour	Positive Behaviour
Trust	Distrust Being judgmental Disconnection Miscommunication Cynical Discomfort Exposure Narrow-mindedness Doubt Loss	Faith in the past, trust in the present and hope in the future Mindfulness Embracing awareness Desire to belong Commitment and loyalty Perseverance	People are out to get me Paranoid Enhanced self-belief in humans No faith in humans Fear of interaction I will never have anything of worth	I will receive all good things by surrendering to love and truth. I can lay down control Survival I can change my perception. Reflective	Attempts to pull others down I don't trust anyone Sceptic Fragile	Always believing in truth and love and being non-judgmental Cognitive choice

7.2.8. Virtue of humility.

The statements made by the counsellors regarding what a person without humility would state fall into three categories: those who are arrogant (“I see myself superior to others”); people who feel submissive (“what others think of me is always correct”); and those who state feelings of guilt (“I am always wrong”). These statements contrast strongly with those a counsellor would see as being evidence of person who has ‘humility’, one who would show gentleness when engaging with their peers and belief in their own growth and ability to care (Table 7.9).Virtue of Humility

Table 0.13
Virtue of humility

Virtue	Negative Emotion	Positive Emotion	Negative Beliefs	Positive Beliefs	Negative Behaviour	Positive Behaviour
Humility	Guilt Shame Wrongful pride Depiction Disadvantaged Arrogance Rudeness Confrontational Submissiveness Captivity	Love Charity Loving my own until the end Wisdom Gentleness Authenticity Confidence Uniqueness	People must think well of me for me to be okay I cannot turn away from evil out of fear of punishment Life is full of negative clutter I do not have the courage to allow myself to feel the suffering of the world I do not have space for humility in my life What others think of me is always correct I am always wrong	I don't need to be somebody I am not in order to be loved. I will believe and live the truth of who I am I can even love my enemies I can simplify my life, by caring and loving myself and others I need to learn and grow from my mistakes I will be mature and wise and happy I will stay connected to my purpose	Taking whatever means is necessary to get people to think a certain way about me. Manipulating people to get what I want and need I stand on others to reach my goals The more people I stand on and disrespect, the better and stronger I feel I will do whatever it takes to win I see myself superior to others	Loving people and seeking truth I abide in His love I make an effort to care for the environment I turn away from pain and move forward to care for others I nurture my ability to fight for all in the protection of life I know my abilities and take full responsibility I have the privilege of being different I spend time with family and friends

Comparison between PAI-2 And WQ Description of Mood and Anxiety Disorders

To further aid the preliminary investigation into the Wellbeing Questionnaire's ability to screen for mood and anxiety disorders, the researcher randomly selected fifteen patient files. These patients had all undergone an independent, psychometric evaluation with the PAI and had been screened with an initial draft of the Wellbeing Questionnaire by the researcher. Subsequently, the researcher compared the results obtained on both measures and took note of which virtues were evidenced as lacking in patients who were diagnosed as 'depressed' or presenting with an 'anxiety disorder'. These results were coded and then tabulated, as discussed below.

7.2.9. Depression.

Table 0.14 Comparison between Depression and Virtues

Depression	Virtues screened in WQ	Attributes of Virtues	
PAI = >70	<Love	*Unforgiveness*	These subjective attributes are normally found in clinically depressed patients.
		Feelings of insignificance	
		Resentment	
	<Joy	*Sadness*	
		Depression	
		Feel inferior	
		Worthless and flawed	
	<Patience	*Impatience*	
		Anger	
		Frustration	
		Insecurity	
		Desire for love substitutes	
	<Goodness	*Fear*	
		Shame	
	<Kindness	*Rejection*	
		Hurt – resulting in fear	
	<Self-Control	*Entitlement*	
		Helplessness	
	<Trust	*Distrust*	
		Judgmental	

Table 7.10 displays the virtues with which the patients were associated when diagnosed with depression. The Personality Assessment Inventory (PAI) evaluates depression as being present when respondents score higher than .70 on the depression scale. Nine patients from the selected fifteen were diagnosed as depressed according to their PAI scores.

In conjunction with being evaluated with the PAI, all nine patients were assessed through an initial draft of the WQ. All the patients reported low scores on the virtues of: love, joy, patience, goodness, kindness, self-control and trust. The associated statements of beliefs, emotions and behaviours recorded with these virtues showed, as in love, patients being unable to forgive and feeling insignificant.

Feelings of insignificance and the inability to forgive others, strongly correlate with the subjective attributes seen in depressed patients. People diagnosed with depression

frequently report feeling inferior to others as well as display repressed anger. This is noteworthy as it suggests that the WQ not only supports the PAI's depression subscale, but also offers a reframing of the criteria when following treatment procedures.

Anxiety.

Table 0.15 Comparison between Anxiety and Virtues

Anxiety	Virtues screened in WQ	Attributes of Virtues	
PAI = <70	<Peace	*Anxiety*	These subjective attributes are normally found in patients clinically diagnosed with anxiety disorder.
		Worry	
		Fear	
	<Patience	*Impatience*	
		Anger	
		Frustration	
		Insecurity	
		Desire for love substitutes	
	<Kindness	*Rejection*	
		Hurt – resulting in fear	
	<Goodness	*Fear*	
		Shame	
	<Self-control	*Entitlement*	
		Helplessness	
	<Trust	*Distrust*	
		Judgmental	
	<Love	*Unforgiveness*	
		Feeling of insignificance	
		Resentment	

Similar to the table on depression (Table 7.10), Table 7.11 regarding anxiety demonstrates associations between PAI scores and the reported statements of the patients in the WQ. The PAI holds that a score above .70 suggests the presence of an anxiety disorder. Taking this into account with the randomly selected patient files, the author found seven patients who fit the PAI's evaluation of presenting a disorder of anxiety.

When the patients were also assessed on the initial WQ questionnaire, they scored low on the virtues of peace, patience, kindness, goodness, self-control, trust, and love. They correspondingly evidenced statements in their beliefs, behaviour, and emotional states that resounded with subjective attributes found in patients with an anxiety disorder. This

is evident in the worry and fear that all the patients expressed, and in turn, their insecurity issues were complemented by a desire for love substitutes.

Consequently, the screening for the WQ corresponds with the PAI's diagnosis. The difference lies in the way in which counsellor and client can discuss their diagnosis, as the WQ allows a description of the concepts because the client may better understand these rather than a score being greater than .70.

Case Study Research

Two cases are drawn upon to further demonstrate positive associations between the WQ and its use in screening for mood and anxiety disorders. These two cases illustrate the potential effects a reframing of disorders in terms of virtues can hold for individuals' understanding of their diagnosis. A discussion follows on how treatments underscored by a virtue-based understanding of wellbeing can have potential benefits for individuals moving from 'dis-ease' to 'well-being'. Both cases were patients of the author and were screened independently with the PAI as well as by the researcher using an initial model of the WQ.

7.2.10. Anne's Case: From medication to virtues.

Anne was referred to the author's practice in 2012 when she was forty-six. By that time she had been diagnosed with major depression since 2003, and had subsequently been diagnosed, in May 2012, with bipolar disorder, depressed episode. Up to that point in time, she had been admitted to a psychiatric facility seven times and had remained in individual psychotherapy since 2003.

At the time of starting treatment with the researcher, she was also on a large number of psychotropic medications, which had been applied over the years, in several different combinations. These medications included: antidepressants (Remeron, Effexor; Eglynol; Cypramil Edronax), anti-psychotics (Abilify; Geodon; Serequel; Zyprexa; Fluanxol) and mood stabilisers (such as Lamotrigine). Following her extremely medicated state, when she first presented herself for treatment, she had a left side tremor, possibly as an extra pyramidal side effect of her continued use of antipsychotic medication, when interviewed by the researcher.

In discussing her past history of treatment, the researcher discovered that in conjunction with her extensive prescription of medication, she had also had convulsive therapy of which she was exposed to seven courses of six electro-convulsive therapy (ECT) sessions. She cited that she had experienced memory problems following each course and that her mood had neither responded to the medical prescriptions that she had been given nor her numerous treatments of ECT. Following this, Anne was also subjected to an electro-encephalogram (EEG) to assess whether she had suffered any neurological damage from her extensive ECT treatments; her brain activity was deemed unaffected.

Following her extensive case history, she was screened with both the PAI-2 and an initial draft of the researcher's WQ. These results are depicted in Table 7.12.

Table 0.16 ***Comparison between PAI and WQ***

PAI	*t*-score	WQ	Scores
Anxiety (physiological)	81	Love	Low
Trauma	82	Joy	Low
Depression (Cognitive)	81	Peace	Low

Depression	(Affective)	99*	Patience	Low
Depression	(Physiological)	84	Forgiveness	Low
Social Detachment		81	Trust	Low
Identity Problems		77	Kindness	Low
			Goodness	Low
			Humility	Low

* indicates that the scores are more than 2 deviations above the mean for a sample of 1, 246 clinical patients

Consulting the table above (Table 7.12) at her PAI-2 and WQ scores, it is evident that Anne was suffering from major depression and not, in the researcher's opinion, bipolar-I disorder. Her Depression (Affective) score, demonstrated an extreme emotional presence, along with the other factors. Her score on the researcher's WQ further posited this, as she scored low on all of the nine virtues that he stipulates are crucial to wellbeing.

In therapy, Anne discussed how the end of a long term relationship triggered her depression, and cited early childhood traumatic experiences of sexual molestation. She also stated that she had asthma and it was evident that she was suffering from obesity[22]. Seeing these presenting issues of wellbeing, the researcher set about building her self-esteem and addressing her virtues while maximising this effect by using therapies based on Dilts'et al (1996) "logical levels models. These therapies included the 'fast phobia cure for trauma during childhood', 'timeline therapy to heal inner child' and other techniques to develop Anne's abilities to handle conflict and criticism.

Over the last two years, following these interventions and discussions of her virtues, Anne has not been admitted once to a psychiatric facility. Anne's medications have also been decreased to only one anti-depressant. More importantly, Anne is fully functional, assertive at her workplace and has had a complete change of life. To cite one example, she has become a marathon runner.

Discussion of Anne's case:

Anne's case, for the researcher, is very important as it demonstrates important features of the argument presented throughout this dissertation, namely that the problems of diagnosis, the importance of free-will, and belief within, aid change throughout a person's life.

Reviewing Anne's case, there appears to be a problem of diagnosis, as she was diagnosed with two very different types of mood disorder (major depression and bipolar-I). Her first years of therapy thus revolved around her debilitating 'label' as a depressed or bipolar person. This was further entrenched in the prolonged use of medication or symptomatic relief, which ironically in Anne's case, provided none except for a plethora of side-effects.

Furthermore, her therapy sessions were centred on talk therapy where she constantly had to speak about her future, without setting any expectation or another set of well-formed outcomes for her wellbeing. In this sense, her therapy, medication, and diagnosis were never in her own hands, but instead, they were passed around between different clinicians. Thus, according to Goswami (2011), this was complete upward-causation in

[22] Mood stabilisers are often associated with people gaining weight (Whalen, k, 2015).

understanding her problems of life and she was not aware that she could take control of her own life.

In moving to a virtues-based understanding of wellbeing which the researcher tried to instil in the sessions, Anne developed her own skills and ways to change her behaviour, attitude, and consequently, her beliefs (and vice versa). A focal point was to develop her forgiveness and peace with her past to allow her to move on and create a set of outcomes that *she* wanted for *her* wellbeing. In creating these outcomes, the virtues of love and trust were developed to help her to feel more optimistic about the future and to love those around her again rather than distrust them.

Anne's recovery speaks of her own ability to facilitate change. It also speaks of the need to engage in a manner of speaking with clients or patients in ways that they can understand. The screening procedure of the WQ proved valuable in developing Anne's understanding of her problems of lifestyle, and was used to help her to develop her own outcomes for the future. Her case speaks of the value of conceptualising wellbeing as the interaction between beliefs, emotions, and behaviour. By changing Anne's beliefs about herself, she was able to change her own life into a more positive one, becoming a 'well' being.

7.2.11. Frank's Case: Overcoming anxiety with self-esteem

Frank is a thirty-eight year old electrical engineer who has had a long history of being anxious. He would spend hours planning a project down to its minutest detail, and if there was a problem in the design or upon implementation of the project, Frank would agonise for days. At work, Frank would often help any colleague who would ask for help, which proved very taxing to himself and his family. He further struggled to talk openly about his feelings and planned his life as he would his work. According to Frank, he had experienced very low self-esteem his whole life and refused to look at himself in the mirror.

These feelings of extreme anxiety and low self-esteem reached a peak in his life. The first being when he was admitted to hospital for three weeks with a diagnosis of Obsessive Compulsive Disorder (OCD) and Attention Deficit Disorder (ADD). He had subsequently been admitted to hospital on two occasions with a diagnosis of bipolar and Post-Traumatic Stress Disorder (PTSD) before starting therapy with the researcher.

Similar to Anne's case, Frank was screened with the PAI-2 and an initial draft of the WQ. His scores indicated heightened affective feelings of anxiety and depression; thus his emotional state was in an extreme state of 'dis-ease' along with several other areas of his mental health. Traumatic Stress was also an extremely high component seen in his psychometric assessment. These results resounded with his scores on his WQ, where all nine virtues were very low.

Table 0.17

PAI		***t*-score**	**WQ**	**Scores**
Anxiety	(Cognitive)	87	Love	Low
Anxiety	(Affective)	96	Joy	Low
Anxiety	(physiological)	75	Peace	Low
OCD		84	Patience	Low

Traumatic Stress		94	Forgiveness	Low
Depression	(Cognitive)	75	Trust	Low
Depression	(Affective)	96	Kindness	Low
Depression	(Physiological)	79	Goodness	Low
			Humility	Low

Using his scores on the WQ as a starting point in sessions, Frank gradually revealed a history of physical, emotional, and sexual abuse. The virtue of love was emphasised in sessions in order to develop his self-esteem. In addition, the focus fell on kindness as well as goodness to develop Frank's abilities to be independent. During therapy, it was indicated to him that he still experienced life as a vulnerable child where he would submit to what others would tell him to do, and this was aiding his feelings of anxiety

After three weeks of individual counselling sessions, Frank stated that he now bases his life on the principle of love. According to him, 'the child' has grown up now. Frank stated that he now knows what he wants out of life and has accordingly lost his addiction to comfort food, smoking, and drinking. He stated that he has had a complete lifestyle change where he feels he has a healthy life and has found purpose in his own life again.

Discussion of Frank's case.

Frank's case reveals the potential impact that a diagnosis may exert upon a person. It also demonstrates the need to deal with a patient's or client's core problem before attempting to move them on to greater wellbeing.

Firstly, Frank's case once again represents another misdiagnosis of a patient's mental health problem. His diagnosis of bipolar/ PTSD and ADD and OCD stipulates a difficulty in proper diagnosis of patient mental wellbeing[23]. This difference in diagnosis resulted in him being admitted to hospital three times, being exposed to three different sets of medication, and other treatments. The ineffectiveness and previous attempts to treat Frank only exacerbated his anxiety problems and further entrenched his core problem of self-esteem and trust issues.

Thus, using a virtue-based screening philosophy with Frank when in therapy allowed him to come to terms with his diagnosis in a way that was familiar to him. It allowed him to see his problems not as deficiencies in his anxiety response, but as experiencing difficulty with loving himself and making peace with his past and present beliefs.

In therapy, the onus between the researcher and Frank was to develop his ability to make peace with the past, resolving his core problem or trauma and its subsequent beliefs. Consequently, this created a state of self-control for Frank and his own belief of trust in the present and hope for the future.

The WQ in both cases thus allowed for the philosophy to become a central tenet in developing patient understanding of their diagnosis as well as allowing the counsellor and client to set outcomes for the person's wellbeing. In this sense, an integrated wellbeing philosophy served not only to screen, but also to develop and aid the clinician in directing therapy and the clients' own beliefs in determining their wellbeing.

[23] *It is in the author's own subjective experience that the combination of OCD and ADD mimics symptoms of bipolar, but because clinicians are reluctant to do differential diagnosis they do not detect this difference.*

7.3. Conclusion

The above research demonstrates potential for a virtue-based integrated wellbeing philosophy for counsellors. As demonstrated in the counsellors' own classification and the subsequent coding of these behaviours, beliefs, and emotions, a virtues-based model is a concept that counsellors can not only describe, but also theorise. Furthermore, the randomly selected sample of fifteen patients that were assessed with both the PAI-2 and WQ showed an association of a lack of virtues with what the PAI-2 scored as depressed or anxious. These associations reveal a potential site of inquiry for future studies and the possible value of the WQ in being used as a wellbeing measure for mood and anxiety disorders.

The two case studies mentioned above also provide useful insight into the possibilities that a virtue-based understanding of wellbeing can hold for clients and counsellors. As the author has discussed, it provides a way to reframe diagnoses in such a manner that clients can understand and value them. Further, it can be used to promote the individual's own sense of facilitating their wellbeing rather than being determined by it, while encouraging the use of techniques which use a virtue-based understanding in treating people with depression and anxiety disorders. In this sense, clients are paced and led to their wellbeing that forefronts the client at the head of the client-counsellor relationship.

These intriguing preliminary results from initial investigations into the field beg further research. The implications and recommendations using a virtue-based model of wellbeing is discussed in the next chapter.

Chapter: 8

The value of Traditional Medicine:

empirical discussion

8.1. Where it All Started

The use of 'plant material' for the treatment of medical conditions, can be dated back more than 6 000 years in both Eastern and Western cultures (Gossell-Williams et al. (2006)). In China, there is evidence of authoritative publications designating the properties, action, use, dosage, and standards of strength as well as the purity of medicines as far back as the reign of Emperor Shen Nung, around 2730 - 3000 BC. These records have described the medicinal use of plants such as Hemp, Aconite, and Opium. The Egyptian Pharmacopoeia of Papyrus Ebers, dating back to about 1500 1550 BC provides evidence of the medical use of plant extracts such as that of Opium

8.1.2. TRADITIONAL MEDICINE

From poppy, the oil of Castor beans, as well as the use of garlic extracts as anticancer medicines (Charlson (1980)). In addition, the 'Materia medica' of Hippocrates, dating back to about 460 - 370 BC, as well as in the manuscripts of Galen, a surgeon from Asia Minor, written around 160 AD, describes the use of plants such as peppermint (Mentha piperita), poppy (Papaver somniferum), mugwort (Artemisia vulgaris), sage (Horminum pyrenaicum), rosemary (Hyssopus oficinalis), rue (Ruta graveolens) and verbena (Verbena o cinalis) (Gossell-Williams et al. (2006)).
Lamoral-Theys et al. (2010) even cited the anti-cancer properties of an extract oil from the da odil Narcissus poeticus deemed to be used by Hippocrates of Cos (B.C. 460370) to treat uterine tumors. His successors, the ancient Greek physicians Pedanius Dioscorides (A.D. 40-90) and Soranus of Ephesus (A.D. 98-138), continued using this therapy in the first and second centuries A.D as well as the Roman natural philosopher Gaius Plinius Secundus (A.D. 23-79), commonly known as Pliny the elder (Kornienko and Evidente (2008)) also made use of different Amaryllidaceae used topical as an anticancer treatment (Lamoral-Theys et al. (2010)). The Bible even provides multiple references to the use of the Mediterranean plant Narcissus tazetta L., which had a long history of use against cancer (Kornienko and Evidente (2008)).

8.1.3. The Foundation of Modern Medicine:

A Neglected Fact Despite the longevity of 'Tradition Medicine', which dates back to the 5th century BC (De Vos (2010)) allopathic medical practitioners and scholars have often been quick to dismiss its effectiveness. De Vos (2010) argues that 'those who wish to present a picture of the triumphal march of western medicine in the modern era portray traditional healing and herbal medicine as profoundly irrational and un-scientific, the stuff of witch-doctors and shamans who did more harm than good' (pp 29). In other words, any possible bene t that patients may have derived from traditional medicine, could only have been, according to Shapiro, 1959 (as cited in De Vos (2010)), as a result of a psychological placebo effect. Accordingly, the debate insists that prior to the 'modern age' these - useless and often dangerous medications - were, according to Sneader, 2005 (as cited in De Vos (2010)), almost wholly ineffective, and those medicines that had beneficial action

were ’the exception rather than the rule’. Apparently, Sneader, 2005 even went so far as to say that claims made for traditional remedies in the past have no validity. Ironically however, despite the countless arguments posed by many medical scholars today, traditional medicine, derived largely from herbal medicine constitute a highly significant component of modern medical care for most of the world’s population today (De Vos (2010)). The significance of which was clearly outlined in 2005 by the World Health Organization report wherein they stated the individual expenditure and use of traditional medicine in both developing and developed countries. It was determined that in Africa, as much as 80% of the population turned to local indigenous methods of healing, while 42% of those surveyed in the United States had apparently sought out alternative or traditional forms of health care at least once in their lives (De Vos (2010)).

During an in-depth survey of the sources of new drug discovery over the past 25 years, Newman and Cragg, 2007 (as cited in De Vos (2010)) determined that the vast majority of ’new drugs’ had resulted from the isolation and imitation of bioactive molecules of natural products. In fact, they maintained that only one new drug, Sorfenib, (an anti-tumor compound), had resulted from chemical synthesis through the method of combinatorial chemistry and high-throughput screening.Despite Sneader’s (as cited in De Vos (2010)), claim that a ’remarkably few (plants and minerals) possess the ability to relieve disease when rigorously evaluated by the criteria of modern, evidence-based medicine’ (pp 29) there is a growing appreciation for the use of Phytonutrients in traditional medicine as well as the use of natural products for new drug discovery as will be shown in the Dissertation. This obvious recognition of the benefits of phytotherapy has led to increased ’bio-prospecting’ into plant products by pharmaceutical companies and private individuals, in order to identify and isolate viable bioactive compounds. According to De Vos (2010) at least 25% (and probably more) of the allopathic medicines prescribed are derive from plants, and that plant based medicine has been found to be effective in the treatment of cancer, HIV, and malaria, so much so that pharmaceutical companies even direct research in this area, especially given the fact that there are in excess of 20,000 (De Vos (2010)) species of plants used in traditional medicines globally, forming the reservoir from which potentially new drugs and medicines are derived.

According to De Vos (2010), the field of Ethnopharmacology as we know it today is as a result of this ever-increasing recognition of the value of traditional medicine and the increasing interest in bio-prospecting. It therefore acts as an interface between the social and natural sciences. Ethnopharmacology primarily focuses on the current and historical use of indigenous knowledge about local plants throughout the world and focuses on having them tested by isolating bioactive compounds that can be used for the treatment of diseases. Sadly, their approach only focuses on the pharmaceutical and commercial perspective and not from a ’traditional use’ perspective. The current Ethnopharmacology research in Africa has therefore come about as a result of the influence of modern education systems and the pressures of industrialization, urbanization and the inculcation of western values. Ironically, almost as a contradiction to the reality as experienced by traditional and natural healers, there is an increased sense of ’urgency’ among researchers to record the ’wisdom of traditional medicine’ and to test the efficacy of this information.

Ji et al. 2009, (as cited in De Vos (2010)), is recorded as having said that 'we have a rich historical record from ancient physicians about how to use natural medicines alone and in combination which, might provide important clues for developing new drugs' (pp 29). The history of which is evident, having already been dated back more than 6000 years.
In concluding their research De Vos (2010), commented that 'Despite the demonstrated longevity and probable effectiveness of traditional western materials medica, however, it is clear that that tradition was largely undermined sometime between 1865 and the present day. Only a handful of samples from the traditional pharmacopoeia are today recognized in the institutional medical world of the west, represented here by the U.S. National Institutes of Health and its listing of herbal remedies' (pp 46). De Vos (2010) suggests that the dramatic change comes about as a direct result of: 'the history of pharmacy and medical chemistry: the development of organic and analytical chemistry, the rise of germ theory, the development of synthetic drugs, and the effect of the Industrial Revolution and the rise of pharmaceutical companies' (pp 46). He believed that all of these influences contributed towards a reduction in the use of traditional medicine, directly as a result of 'scientific, political, and economic motives' (pp 46). He continued by saying that 'these medicines, used for thousands of years, may very well provide important new avenues for pharmaceutical research' (pp 46).

There is a lesson to be learnt by African and Western Countries from the practices of countries such as Japan, Korea, India and China, where Phytonutrients and Neutraceuticals are often administered by a practicing medical professional even although they are classified as traditional 'medicines' (Mazzio and Soliman (2009)). Once a malignancy has been diagnosed and established, Phyto therapeutic choices would serve to augment chemotherapy, even directly contribute toward tumor suppression, prevent metastasis and establish remission. This sort of practice seems inevitable especially in lieu of the fact that up to 91% of cancer patients worldwide source some form of CAM to augment traditional chemotherapy (Mazzio and Soliman (2009)). Mazzio and Soliman (2009) determined that the largest percentages of users self-medicate with herbs, herbal teas, vitamins and minerals without any apprising medical professionals involved. Their research also revealed that the highest use was observed in patients presenting with breast, colon, lung, head and neck cancer. Given these facts, it would be a lot better if there was corroborating evidence for the use of CAM in any treatment situation - a role for unbiased Ethnopharmacology research.

8.1.4. The Advent of Modern Chemistry

The development of modern Chemistry has allowed for the identification and isolation of active compounds, deemed to have greater therapeutic value, from within plants which have provided data from which synthetic derivatives can be generated that are of even greater monetary value when sold than as natural compounds alone. This form of research and development initially led to the identity cation and interpretation of the chemistry of Opium, which subsequently led to the isolation of morphine and the synthesis of many other synthetic derivatives used medically today (Gossell-Williams et al. (2006)). According to Gossell-Williams et al. (2006) it is this scientific framework that ultimately lead to a preference for medicines made largely from pure chemical compounds. However, even when given all the perceived benefits associated with drug development and usage, many health-related conditions remain unresolved. However, despite the marvels of drugs, the World Health Organization (WHO) estimates that 4 billion people, approximately 80% of the World's population, currently make use of herbal medicines for some aspect of their primary healthcare (Gossell-Williams et al. (2006)), whilst others such as Bungu, (2005) estimate

that as many as 86% of cancer patients use some form of traditional medicine (as cited in Gossell-Williams et al. (2006).

Freidberg (2009), has attested to the fact that an ever-increasing interest in novel plant-derived drugs has been witnessed over the years. In his opinion this has largely been as a result of the reality that conventional medicines are often ineffective and cause side effects, as well as the fact that they are also inaccessible for a large percentage of the world's population, and that it is also believed by many that traditional medicine is safer to use. By 2006 it was already estimated that approximately 72,000 plant species, accounting for about 17% of the world's higher plant flora, had already been made use of for medicinal purposes worldwide (Miththapala (2006)). According to Miththapala (2006) these figures are said to exclude the use of lower plants, and the different fungi that are also being used medicinally by people from many different cultures. By 2006 it was already estimated that the value in the global trade of over the-counter medicinal plants exceeded text dollar 40 billion per year globally. As a contribution to this trade African and Asian countries were then believed to have exported about 400,000 tons of medicinal plants to Europe each year. Perhaps what is of even more significance is that by 2006 it was already estimated that more than 50% of drugs prescribed in the USA were copied from chemical compounds derived from natural sources (Miththapala (2006)).

8.2. A Review of Health and Disease Management

McClure (2002) argues that with the introduction of powerful drugs and better technology, allopathic medical practice appears to have primarily established itself as a system of disease management with a focus on the diagnosis and treat of disease, and not a system that promotes good health. A system in which the patient is expected to participate passively whilst the doctor dictates a treatment the patient is expected to follow. Whilst on the other hand, McClure (2002) maintains that Holistic Medical Practitioners strive to prevent disease by facilitating the natural healing power of nature in addition to teaching their patients how to access and identify the skills and practices deemed necessary for self-healing. He argues that these practitioners strive to identify and treat the cause of disease (Tolle Causam), whilst applying the minimum therapy necessary to restore balance, instead of merely suppressing symptoms as appears to be common practice amongst allopathic practitioners. Given this approach, patients are expected to play an active part in a customized treatment program facilitated by their practitioners, with an invitation to rather identify the manifestation of their condition on a physical, psychological, and spiritual level.

In Africa, as in other Third World Countries the use of 'Natural Medicine' continues to be widely practiced for a variety of reasons other than just for 'Traditional' ones. Joy et al. (1998) suggested that the increase in population, the shortages of allopathic medication, the unavoidable costs associated with treatments are the primary motivators behind the use of phytonutrients as an alternative to allopathic medication. However, they also contest that the side effects of several allopathic drugs as well as the development of a 'resistance' to certain drugs for infections and other diseases have intensified the current choice for many people to use phytonutrients as a source of medicines for a wide variety of human ailments, in addition to encouraging ethnobotanical research for new medicinal compounds. Despite the entrenched 'legal' position allopathic medicine holds in many societies, the overwhelming influences of governmental organisations, the dependence on modern medicine and the tremendous advances in synthetic drugs, a large percentage of the world population still make use of phytonutrient products (Joy et al. (1998)). Traditions aside, perhaps the single most important reason why the inhabitants in developing countries not only persist with the use of phytonutrients but are actually increasing consumption thereof

is the fact that allopathic 'lifesaving drugs' are not affordable to three quarters of the third world's population (Joy et al. (1998)).

wide variety of ailments should both be accessible and affordable. In contrast to the point raised above, Taylor et al. (2001) remind us that there has seldom been effective collaboration between the Traditional and Western medical practitioners, largely as a result of the perception that the use of traditional phytonutrients has no scientific basis. Regardless of perceptions or personal opinions the current Ethnomedical research in Africa clearly demonstrates that there is a renewed interest in herbal remedies and that the increasingly urgent need to develop more effective drugs, traditionally used medicinal plants are currently receiving the attention of the pharmaceutical and scientific communities both in African and in the Western countries alike (Taylor et al. (2001)). Perhaps a contentious point needs mentioning here in that the current research is primarily focused on the identity cation and isolation of secondary metabolites inherent within the botanicals which are then used as the principle agents in allopathic medical preparations without any 'acknowledgement or bene t' to traditional healers. The research therefore only focuses on the scientific validation of Southern African medicinal plants for used in allopathic medical formulations and does not, unfortunately, validate, promote or encourage its use as phytonutrients as prescribed by Traditional healers per se. Scientific ratification of the use of these phytonutrients would go a long way in even 'reverse-educating' traditional healers as to other potential uses for the plants and in doing so also help contribute towards affordability issues surrounding treatment for numerous ailments. Unfortunately, knowledge is not shared easily and comes at a huge premium on the one hand and a serious disadvantage to the 'sick people'.

So, although Modern and Traditional health-care practices exist side by side in developing countries, they seldom, if ever cooperate, despite the important contribution that the knowledge of the use of herbal medicine has made to allopathic health-care over the centuries. Without traditional knowledge, where would conventional medicine be? Taylor et al. (2001) contend that this situation is predominantly as a result of the following reasons: a lack of scientific evidence for the use of most phytonutrients; a lack of standardization with regards to raw materials, questionable methods of production as well as quality control of the finished product. As far back as 1978, the WHO proposed that traditional medicine did not keep pace with scientific and technological advancement, and that its methods, techniques, medicines and training were often kept a secret. The question however, should be on whether these criticisms still apply today.

Taylor et al. (2001) maintain that although ethnopharmacological studies are able to make a significant contribution to the practice of modern medicine with novel and useful drugs, the modern and traditional uses may be entirely different. Be this as it may, the reasons are quite evident in the research literature. The active compounds found within plants are either in the leaves, roots, bark, or flowers and stems and often are able to differ considerably in concentration as is normal within natural products where conditions have a significant effect on the quality and quantity of metabolites within the plant structure. In addition, it is also possible that one part of a plant may be harmless whilst the other could be toxic. Given these facts traditional medicine, if anything is not a static system but rather dynamic and adaptive as a result of the inconsistent influence of 'nature', irrespective of the political environment in which natural medicine exists. Even although an e ort may be made with regards to the introduction of allopathic medicinal standards and practices, such as standardization of doses, quality control etc., all of which may improve traditional healing practices, trying to validate the efficacy of phytonutrient products with the same standardization, control measures and practices, as applied to allopathic medicine is neither feasible nor logical, given the inherent natural inconsistencies found within nature. Standardization practices applicable to the manufacture of natural medicines need to be

established on their own accord, taking into consideration all the necessary challenges that nature has to offer.

It needs to be acknowledge that the use of 'whole plant parts' do offer a chemical advantage in that the 'sum total of all the chemical structures' within the plant, have to provide some medicinal advantage, considering the value of the role of essential cofactors, as opposed to the isolation of single extracts, no matter how advantageous they may be. Advantages that the scientific community themselves may not necessarily be able to explain. In other words, an extract using the whole plant or part thereof may contain advantages not evident in the use of isolated single extracts on their own. In other words, a potential medical solution may not necessarily lie in the extraction and isolation of specific secondary metabolites but rather in the synergistic application of these metabolites amplifying each other.
Perhaps what also needs to be highlighted at this juncture is that the research on 'Natural products' has primarily been developed with a focus on identifying and isolating specific secondary metabolites and compounds with a particular biological and chemical activity. Essack (2006) highlights this point by adding that pharmacological and phytochemical insights into several plants have either contributed towards the discovery of novel chemicals leading to the development of novel drugs, or to novel chemical structures serving as lead compounds/templates for the design of new drugs. The argument is not that one form of research needs to be replaced by another, but rather that allowances should be made for additional and different forms of research. If an extracted secondary metabolite or compound is capable of working in isolation, then why could they not also work collectively with the other compounds as found in whole plant structures?

8.3. Bureaucracy: An interfering Mechanism in Change

A question that needs to be addressed is whether Governmental Institutions and Medical organisations subsidise 'illnesses' or whether they promote 'wellness'. There is a huge disparity between the total expenditure by individuals and insurance organisations, as well as Governmental budgets allocated for the treatment of diseases versus investments directed towards programmes encouraging wellness. So much for the adage prevention is better than cure.
The unceasing work over the years, conducted by a few 'Renegade' practitioners who have been willing to go beyond their prescribed duty and training, who have ventured into seeking more effective and efficient modalities through which treatment, diagnostics and an alternative understanding of poor health and dis-ease in patients may be managed, needs to be commended and supported rather than sneered and ridiculed as often happens. Many of these Men and Women have single-handedly challenged the 'status quo' that is jealously guarded by the Bureaucratic gatekeepers who arguably guard an old and often outdated medical curriculum, perhaps too afraid to

Figure 8.1 traditional medicine
https://www.sciencedirect.com/science/article/pii/S0254629912000762

accommodate change, as if change itself would compromise the gains that have been made. Perhaps the fault lies in the fact that unlike politics, there is no democracy in business.... but at the least there should be sufficient representation of all interested parties instead of the autocracy that exists.

As has already been mentioned, perhaps the biggest stumbling block lies in being able to determine and identify what may be construed as 'scientific evidence' given the research into the use of phytonutrients that is taking place, or rather how evidence of efficacy may be validated especially in so far as the use of phytonutrients is concerned. The biggest single challenge, I believe, lies in finding ways in which botanicals may be cultivated, so as to maximise the quantity and quality of active ingredients and to establish standardised international norms for the use of phytonutrient in any given protocol compiled with natural products. Given this fact perhaps the question that needs to be answered is whether the double-blind study and the principle of 'caeteris paribus' (a Latin phrase, used by analysts to apply simplifying assumptions in order to devise or explain an analytical framework that does not necessarily prove cause and effect but is still useful for describing fundamental concepts within a realm of inquiry) should be applied when determining the efficacy of research into the use of natural compounds to be used for medicinal purposes, or whether other stringent criteria need to be determined so as to accommodate the natural inconsistencies evident in nature. I believe that new validating standards should include both qualitative and quantitative measures in determining and ascertaining efficacy. Perhaps it is time for some change in the medical model to accommodate integrative and evidence-based medicine and health practices. Perhaps there needs to be a review as to who should determine and represent the rights of the patient.

8.5. The benefits and challenges of a wellness practice in the Tembisa, South Africa: case Study.

This article will answer the following question: what are the benefits and challenges of a wellness practice in the Tembisa community in South Africa?

8.5.1. The aim

The aim of this article was to find out whether the people of Tembisa are benefiting from a wellness practice which is located in the area, which offers services such as counseling, lifestyle coaching, and education about nutrition (especially the use of herbs) as well as testing of ailments using the quantum resonance analyzer. This articles will also give a picture on how much knowledge does the community have, with regard to awareness on wellness; which involve proper nutrition,(use of herbs, supplements, vegetables, fruits, adequate water intake and more), exercising, the mental being, spiritual being, the socio economic effects and other aspects of wellness.

8.5.2. Methodology

An empirical method has been used in this research and information have been gathered through non theoretical research as the nature of this research suits this methodology. A survey was conducted to 20 clients who consult in the wellness practice. Other people were interviewed as well.

8.5.3. Wellness definition

Wellness is much more than merely physical health, exercise or nutrition. It is the full integration of states of physical, mental, and spiritual well-being. The model used by our campus includes social, emotional, spiritual, environmental, occupational, intellectual and physical wellness. Each of these seven dimensions act and interact in a way that contributes to our own quality of life.

8.5.3.1. **Social** Wellness is the ability to relate to and connect with other people in our world. Our ability to establish and maintain positive relationships with family, friends and co-workers contributes to our Social Wellness.

8.5.3.2. **Emotional** Wellness is the ability to understand ourselves and cope with the challenge's life can bring. The ability to acknowledge and share feelings of anger, fear, sadness or stress; hope, love, joy and happiness in a productive manner contributes to our Emotional Wellness.

8.5.3.3. **Spiritual** Wellness is the ability to establish peace and harmony in our lives. The ability to develop congruency between values and actions and to realize a common purpose that binds creation together contributes to our Spiritual Wellness.

8.5.3.4. **Environmental** Wellness is the ability to recognize our own responsibility for the quality of the air, the water and the land that surrounds us. The ability to make a positive impact on the quality of our environment in our homes, our communities or our planet contributes to our Environmental Wellness.

8.5.3.5. **Occupational** Wellness is the ability to get personal fulfillment from our jobs or our chosen career fields while still maintaining balance in our lives. Our desire to contribute in our careers to make a positive impact on the organizations we work in and to society as a whole lead to Occupational Wellness.

8.5.3.6. **Intellectual** Wellness is the ability to open our minds to new ideas and experiences that can be applied to personal decisions, group interaction and community betterment. The desire to learn new concepts, improve skills and seek challenges in pursuit of lifelong learning contributes to our Intellectual Wellness.

8.5.3.7. **Physical** Wellness is the ability to maintain a healthy quality of life that allows us to get through our daily activities without undue fatigue or physical stress. The ability to recognize that our behaviors have a significant impact on our wellness and adopting healthful habits (routine checkups, a balanced diet, exercise, etc.) while

avoiding destructive habits (tobacco, drugs, alcohol, etc.) will lead to optimal Physical Wellness.

8.5.4. Definition of holistic health

Holistic health is a wellness approach that addresses the body, mind and spirit or the physical, emotional/mental and spiritual aspects of an individual.

Traditional medical doctors treat the body and ignore the mind, conventional mental health professionals treat the mind and ignore the body. Neither one of them address the spiritual. Both of them treat symptoms with drugs or surgery rather than looking for what causes the symptom.

A holistic health approach does not view the body, mind and spirit as separate entities and promotes drugs and surgery only when absolutely essential and after other solutions have been sought. It looks for the underlying causes of symptoms, rather than just covering up the symptoms with a drug.

The body, mind and spirit are not independent of one another. They are intertwined. What affects one affects the others. A philosophy that focuses on only one aspect is an incomplete approach.

The definition of holistic health may encompass many different elements depending on which field of thought you're dealing with. It is sometimes referred to as complimentary health, alternative health or natural health. These terms are often, but not always interchangeable. A treatment approach can be complimentary, alternative or natural without necessarily being holistic. However, most holistic approaches are considered to be complimentary, alternative or natural.

Treatment approaches are highly individualized for the unique needs of each individual and the patient and their practitioner make decisions together as partners to develop the health care plan.

Many different kinds of health practitioners embrace a holistic health approach. Mental Health Counselors, educators, chiropractors, naturopaths, doctors of environmental medicine, homeopaths, dentists and even some medical doctors are becoming enlightened. Holistic nursing is a field that is growing fast in popularity.

Within the holistic health concept you're likely to find a variety of different treatment approaches. The focus may be on avenues such as environmental health, acupressure, nutritional counseling, massage, homeopathy, meditation, dietary changes, food allergies, vitamin supplementation, exercise, oxygen therapies, herbs, organic living to name a few.

There are a variety of holistic health organizations designed to advocate holistic health, inform the public, and assist practitioners that can help you achieve a better understanding of holistic principles and guide you to the resources you may desire.

A definition of holistic health would not be complete without highlighting the fact that wellness approaches in the holistic field are considered to be wholesome, healthy and not harmful or toxic to the individual or the environment. They promote balance and harmony for the individual, society and the planet.

A holistic approach encourages the individual to engage in self-care and educate themselves about their health. It urges them be an active participant in their treatment and health care, rather than giving all the power to a health care provider.

Here at Holistic Help my focus is on improving mental, physical and spiritual health issues through diet, nutrition, changes in lifestyle and awareness of environmental toxins. Being healthy does not necessarily mean the absence of disease or illness. It is about living as completely and optimally as possible with the hand you have been dealt and the limits that you face, while at the same time pursuing options that will improve your hand.

8.5.5. The definition of nutrition

Nutrition can be defined as the study of food in relation to physiological processes that depend on its absorption by the body to provide growth, energy production, and the repair of body tissues. Nutrition includes the absorption and assimilation of nutrients by the tissues. The science of nutrition also includes the study of diets and of deficiency diseases. Therapeutic nutrition concerns itself with the way health can be enhanced by using specific nutrients. Wellbeing on the other hand can be defined as the balance between and integration of all those aspects that make up our existence. Food and nutrients along with medicinal plants (herbal remedies) have to do with the bio-chemical functioning of the human body. The human body (and that of animals) has an innate healing mechanism by which it restores imbalances. Homeostasis can only be achieved where the correct amount of nutrients can be absorbed by the human body. Increasing research is nowadays being conducted into the therapeutic value of nutrients. Therapeutic nutrition means that disease conditions can be treated (or prevented) by using certain nutrients or diets. The dieticians and the nutritionists seem to be the doctors of the 21st century. Diet and nutrition forms part of wellbeing, to understand the value of therapeutic nutrition, we need to see it within the context of wellbeing in natural health care which is carried by the epistemic matrix of a holistic or integrated approach to self-understanding. Elements of self-care, life style, proper nutrition and emotional well-being all form part of this regimen. Within this growing tide of interest in nutrition and health which takes us beyond suboptimal nutrition that is common in nature to a level where we are challenged to approach the optimum nutrition level where the organism becomes enabled to grow and perform with increasing vigor. The opposite is illustrated in clinical studies; where tissue culture experiments have shown that the nutritional deterioration of the medium is directly proportional to the deteriorating growth and vigor of cells. Insights, such as these, may constitute a very important contribution to the social input in primary health care since the availability of good nutrition is ultimately a social issue. Yet, the social dimension rarely figures in primary health care.

Chapter 9

work-based evidence: empirical research

Tembisa community research on wellness awareness

9.1. The research

This research will answer the following question: what are the benefits and challenges of a wellness practice in the Tembisa community in South Africa?

9.2. The aim

The aim of this research was to find out whether the people of Tembisa are benefiting from a wellness practice which is located in the area, which offers services such as counseling, lifestyle coaching, and education about nutrition (especially the use of herbs) as well as testing of ailments using the quantum resonance analyzer. This articles will also give a picture on how much knowledge does the community have, with regard to awareness on wellness; which involve proper nutrition,(use of herbs, supplements, vegetables, fruits, adequate water intake and more), exercising, the mental being, spiritual being, the socio economic effects and other aspects of wellness.

9.3. Methodology

An empirical method has been used in this research and information have been gathered through non theoretical research as the nature of this research suits this methodology. A survey was conducted to 20 clients who consult in the wellness practice. Other people were interviewed as well.

9.3.1. Questionnaire

1. Do you think there is enough education on wellness in your community?

2. Have you gain knowledge that you think can help you in changing your lifestyle from this practice?

3. Were you ever taught/ advised by a healthy practitioner about the importance of good nutrition?

4. Are you currently exercising at least 3 times a week?

5. Would you recommend that wellness practices such as this should be established in clinics and hospitals?

6. Have you been using herbs and supplements before?

7. Do you think herbs are effective?

8. What do you prefer between using herbs or drugs/conventional medicine……...? And what is your reason?
.....

9. How would you rate the quantum physic analyzer machine's accuracy; Not accurate…., accurate……, very accurate…...?

10. Do you think the price of herbs fair or not?

11. What would you suggest for improvements in this practice……...?

9.3.2. The data and its implications

The data clearly shows that there is not enough wellness awareness around the community of Tembisa as 75% of the survey indicated that there not enough education in the community on awareness, this means that there is a need for our government to pay more attention in bringing awareness to this community about wellness. This is a serious challenge because community-based programs help the community to get involved in promotion awareness to healthy related issues. This is one reason public health education should become such a vital tool to help communities fight against the spread of illnesses and diseases. The following reasons help to further explain the benefits of ongoing public health education;

- **The public learns methods to prevent the spread of disease**; A public health educator's objective when a communicable disease threat is present is to teach members of the community. The public will have better access to the information they need about the basic prevention of disease. This knowledge includes what they should do, and how they should react when an epidemic occurs in their area. Specific diseases do have unique prevention methods that all individuals should be aware of. They should also know that applying these techniques when around others will reduce their risk of exposure and infection. Public health education is effective when the community knows to wear a flu mask in certain areas, or to take certain vaccines to prevent illness during some months of the year.
- **Public health education encourages people to get regular medical checkups;** The majority of people in a community are able to access hospitals, clinics and doctor's offices for disease prevention and the prevention and treatment of medical conditions. Without an effective public health education program, it is likely that people who feel healthy would not see the importance of having regular health check-ups. Being aware that you need to visit your doctor for wellness checks is something that is taught and encouraged by health care law degree online professionals. Hospitals and clinics offer flu shots and vaccines during the yearly flu season, or when there is an outbreak of an infectious disease. Public health education helps to ensure that the more people schedule an appointment at these facilities to get the necessary treatment the further spread of illness.

- **People adopt healthier lifestyles;** Public Health Education also teaches members of the community how to reduce the risk of disease in their personal spaces. For example, they learn that keeping a cleaner house reduces the spread of disease, sickness and pest infestations. They also begin to realize that reducing or eliminating smoking can improve their health and increase their longevity.
- **Public health education helps to dispel myths;** Public perception and myths are quickly dismissed when the community is given the proper information about an illness or disease. Public health education not only teaches illness prevention, it also helps to provide key details of how a disease is truly spread. This helps to change the way a person interacts and it also helps to promote empathy instead of discrimination. Public health educators are key members of a community who use education to advocate health. This education helps to foster closer communities.

9.3.3. The research also shows that people felt informed about wellness after consulting in the practice and committed themselves to change their lifestyle by having good nutrition. About 85% of the survey participants have indicated that the wellness practice has helped them in gaining about healthy related issues. Good nutrition is an important part of leading a healthy lifestyle. Combined with physical activity, your diet can help you to reach and maintain a healthy weight, reduce your risk of chronic diseases (like heart disease and cancer), and promote your overall health. Unhealthy eating habits have contributed to the obesity epidemic in the communities, Even for people at a healthy weight, a poor diet is associated with major health risks that can cause illness and even death. These include heart disease, hypertension (high blood pressure), type 2 diabetes, osteoporosis, and certain types of cancer. By making smart food choices, you can help protect yourself from these health problems.

The risk factors for adult chronic diseases, like hypertension and type 2 diabetes, are increasingly seen in younger ages, often a result of unhealthy eating habits and increased weight gain. Dietary habits established in childhood often carry into adulthood, so teaching children how to eat healthy at a young age will help them stay healthy throughout their life.

The link between good nutrition and healthy weight, reduced chronic disease risk, and overall health is too important to ignore. By taking steps to eat healthy, you'll be on your way to getting the nutrients your body needs to stay healthy, active, and strong. As with physical activity, making small changes in your diet can go a long way.

9.3.4. The research also shows that people in this community have a minor general knowledge about the importance of nutrition. 95% of the participant alluded to fact that they were in one way or other informed about good nutrition but not a point where they understood the real meaning of it. To ascertain whether the people use the knowledge they had put to practice, 5 clients were interviewed to ascertain their usual diet, physical healthy conditions related to their age, and

use of medicines, supplements and herbal remedies. Below is an assessment report of a case study which was conducted from clients in the practice who had diseases as a result of lack of good nutrition;

9.4. Case study 1

9.4.1. Client 1

Age: 58 years

Complaint/disease: arthritis

Questionnaire

i. Any disease that causes you to change the way you eat? arthritis

ii. Eating too little or too much? Too much

iii. Do you smoke? no

iv. Do you consume a lot of junk food? moderate

v. Do you drink enough water every day? yes

vi. What do you usually eat? White rice, red meat, chicken or sour milk and porridge.

vii. Any problems with finance? Not that much

viii. Any loneliness feeling? no

ix. Have you been taking any medicine that affects your appetite? no

x. Have you noticed any involuntary weight loss or gain recently? no

xi. How often do you exercise? 3 times a week

xii. Are you using any medicine at the moment? Yes, from GP

xiii. Are you using any herbs or supplement? Folic acid, vit BCom

My assessment is that this client is suffering from arthritis not because of stress or bacteria but because of poor nutrition as result of eating junk food and unbalanced nutrition, there are also no herbs in is diet nor enough supplement. He needs add more non acidic fruits and vegetables in his diet. He also needs to stop eating the white rice and use brown rice whole grains. Even though he is not obese he needs to spend a little bit more time in the gym than he is spending now. Herbs such as Siberian ginseng, dandelion root, alfalfa and ginger can also be of beneficial for him. He also needs to avoid red meat in his meal because red meat is one of the primary causes for this disease.

9.4.2. Client 2

Age: 67 years

Female

Complaint/disease: high blood pressure

Questionnaire

i. Any disease that causes you to change the way you eat? HBP

ii. Eating too little or too much? Not much

iii. Do you smoke? no

iv. Do you consume a lot of junk food? Yes

v. Do you drink enough water every day? Yes

vi. what do you usually eat? chicken and porridge.

vii. Any problems with finance? yes

viii. Any loneliness feeling? Sometimes

ix. Have you been taking any medicine that affects your appetite? No

x. Have you noticed any involuntary weight loss or gain recently? No

xi. How often do you exercise? Not exercising

xii. Are you using any medicine at the moment? HBP pills from GP

xiii. Are you using any herbs or supplement? Cabbage and spinach vegetables

HBP is more common to older people as blood cholesterol levels begins to sharply increase around the age of 40. This client clearly does not have a balanced diet in her usual meals. she needs to add fruits in her diet such as apples bananas and apples. Also, high fibre food will be of great help. She also has to take supplements such as vitamin c which help to lower high blood pressure. Herbs such hawthorn berries, garlic, alfalfa, ginger, turmeric and ginseng can also be great help for her. Regular exercising will be of great help a she currently not exercising. It is clear that she gets stressed sometimes because of her finances, to avoid getting stressed she needs to think positive and perhaps associate herself with people who will motivate her like a church.

9.4.3. Client 3

Age: 40 years

male

Questionnaire

i. Any disease that causes you to change the way you eat? Fatigue

ii. Eating too little or too much? Too little

iii. Do you smoke? no

iv. Do you consume a lot of junk food? Yes

v. Do you drink enough water every day? no

vi. what do you usually eat? Porridge, red meat, salads

vii. Any problems with finance? yes

viii. Any loneliness feeling? no

ix. Have you been taking any medicine that affects your appetite? No

x. Have you noticed any involuntary weight loss or gain recently? Loss weight

xi. How often do you exercise? Not exercising

xii. Are you using any medicine at the moment? no

xiii. Are you using any herbs or supplement? multivitamins

This client complained about being tired most of the time, he has lost appetite and weight. He has financial problems as well. He was advised to ensure a balanced diet , to avoid sugar and stimulants such as coffee and alcohol. Herbs such as ginseng and liquorice may be used as a supplement. Buchu can also help him for detoxing. Supplements such as multi-B complex, vitamin c and zinc can also assist him. He also have to regularly exercise, think positive and review his lifestyle.

9.4.4. Client 4

Age: 27 years

Male

Complaint/disease: heartburn

Questionnaire

i. Any disease that causes you to change the way you eat? no

ii. Eating too little or too much? moderate

iii. Do you smoke? no

iv. Do you consume a lot of junk food? Yes

v. Do you drink enough water every day? no

vi. what do you usually eat? Porridge, red meat, sour milk, fizz

vii. Any problems with finance? no

viii. Any loneliness feeling? no

ix. Have you been taking any medicine that affects your appetite? No

x. Have you noticed any involuntary weight loss or gain recently? no

xi. How often do you exercise? regular exercising

xii. Are you using any medicine at the moment? no

xiii. Are you using any herbs or supplement? no

Heartburn is a feeling of burning or pain in the upper abdomen just beneath the lower breastborne. It occurs when the esophagus is not functioning properly and allows stomach acid to escape to the esophagus. The client does not have a balanced diet and his nutrition intake is not sufficient. He also drinks a lot of cold drinks which worsen his situation. I advised him to use aloe vera juice to heal the intestinal tract, fennel is also good for him to ensure proper digestion and act as a buffer to stop the heart burn. Liquorice is also good to treat heartburn and ulcers. With regard to nutrition; he needs eat more raw vegetables and eat smaller but frequent meals and chew his food well. I also advised him to make sure he eats at least 3 hours before bedtime. He must also use supplements such as calcium and magnesium as they have an alkaline effect that binds up stomach acid. He was also advised to avoid stress and anger, elevate head on his bed pillow and exercising regularly.

9.4.5. Client 5

Age: 27 years

Male

Complaint/disease: heartburn

Questionnaire

i. Any disease that causes you to change the way you eat? no

ii. Eating too little or too much? moderate

iii. Do you smoke? no

iv. Do you consume a lot of junk food? Yes

v. Do you drink enough water every day? no

vi. what do you usually eat? Porridge, red meat, sour milk, fizz

vii. Any problems with finance? no

viii. Any loneliness feeling? no

ix. Have you been taking any medicine that affects your appetite? No

x. Have you noticed any involuntary weight loss or gain recently? no

xi. How often do you exercise? regular exercising

xii. Are you using any medicine at the moment? no

xiii. Are you using any herbs or supplement? no

9.4.6. Client 6

Age: 71 years

Male

Complaint/disease: impotence

Questionnaire

i. Any disease that causes you to change the way you eat? cholesterol

ii. Eating too little or too much? moderate

iii. Do you smoke? yes

iv. Do you consume a lot of junk food? Yes

v. Do you drink enough water every day? yes

vi. What do you usually eat? Porridge, beans, red meat, sour milk, fizz

vii. Any problems with finance? Not that much

viii. Any loneliness feeling? no

ix. Have you been taking any medicine that affects your appetite? No

x. Have you noticed any involuntary weight loss or gain recently? no

xi. How often do you exercise? regurlar exercising

xii. Are you using any medicine at the moment? Yes

xiii. Are you using any herbs or supplement? no

When asked about whether they exercise adequate; the survey shows that only 35% of the participants are exercising adequate while 65% indicated that they do not exercise adequate. This is very unfortunate for this community as lack of exercising is the main cause of many diseases. Exercising has benefits such as the following;

9.4.6.1. Exercise controls weight

Exercise can help prevent excess weight gain or help maintain weight loss. When you engage in physical activity, you burn calories. The more intense the activity, the more calories you burn. Regular trips to the gym are great, but do not worry if you cannot find a large chunk of time to exercise every day. To reap the benefits of exercise, just get more active throughout your day, take the stairs instead of the elevator or rev up your household chores. Consistency is key.

9.4.6.2. Exercise combats health conditions and diseases

If one is worried about heart disease, or Hoping to prevent high blood pressure; No matter what their current weight, being active boosts high-density lipoprotein (HDL), or "good," cholesterol and decreases unhealthy triglycerides. This one-two punch keeps your blood flowing smoothly, which decreases your risk of cardiovascular diseases. Regular exercise helps prevent or manage a wide range of health problems and concerns, including stroke, metabolic syndrome, type 2 diabetes, depression, a number of types of cancer, arthritis and falls.

9.4.6.3. Exercise improves mood

A gym session or brisk 30-minute walk can help. Physical activity stimulates various brain chemicals that may leave you feeling happier and more relaxed. You may also feel better about your appearance and yourself when you exercise regularly, which can boost your confidence and improve your self-esteem.

9.4.6.4. Exercise boosts energy

Regular physical activity can improve your muscle strength and boost your endurance. Exercise delivers oxygen and nutrients to your tissues and helps your cardiovascular system work more efficiently. And when your heart and lung health improve, you have more energy to tackle daily chores.

9.4.6.5. Exercise promotes better sleep

Regular physical activity can help you fall asleep faster and deepen your sleep. Just don't exercise too close to bedtime, or you may be too energized to hit the hay.

9.4.6.6. Exercise puts the spark back into your sex life

Regular physical activity can improve energy levels and physical appearance, which may boost your sex life. There's even more to it than that. Regular physical activity may enhance arousal for women. And men who exercise regularly are less likely to have problems with erectile dysfunction than are men who don't exercise.

9.4.6.7. Exercise can be fun … and social!

Exercise and physical activity can be enjoyable. It gives you a chance to unwind, enjoy the outdoors or simply engage in activities that make you happy. Physical activity can also help you connect with family or friends in a fun social setting.

The research also indicated that the people of this community would love practices as this to be integrated to clinics and hospitals as part of the primary health care system. This clearly shows that people are quite happy about the holistic approach. 70% of the participants have recommended that wellness practices should form part of the primary health care.

The good news is that there is proposal to restructure primary health care in South Africa provides the perfect opportunity for complementary and alternative medicine to be formally integrated into the country's health system.

Complementary and alternative medicine is any practice of medicine that is outside mainstream conventional allopathic medicine. Some of these medicines may be sourced from natural herbs and are referred to as herbal medicines. They are used, among others, as remedies for a variety of ailments like coughs and insomnia and as dietary supplements and weight loss.

In South Africa, as in many other countries, these alternative treatments are used alongside conventional medicines rather than exclusively. They are also chosen by patients rather than prescribed to them, which creates a complementary rather than an alternative practice.

In 2014 the government amended the Medicines and Related Substances Act. Practitioners of complementary and alternative medicine are now officially recognised and are obliged to register with the a statutory body.

The amendment has been seen as the government acknowledging complementary and alternative medicines, but it has not translated into their inclusion into health policy. There is still much to be done before there's symbiosis between these two systems.

9.4.7. Filling a critical gap

South Africa's private health care system is rated among the best in Africa, with facilities said to be comparable to those in developed economies.

Against this backdrop it may seem counter-productive to focus on the integration of conventional with complementary health approaches. But the reality is that the population's health care demands are not being met. This is particularly true in the country's rural areas, where access to basic conventional health care is extremely limited.

In these rural settings, complementary and alternative medicine practices are common. The rich diversity of South Africa means there are a variety of alternative medicine approaches. However, current literature provides little information on its use.

Fully including these treatments into the health care programs would ensure that safety, quality and efficacy studies are available and regulated. This is particularly important given the potential of side effects that the existing health care system may be unaware of or is ill-prepared to manage.

9.4.8. A global picture

Across the globe, only a few countries have achieved full integration. These include China, Korea and Vietnam.

But there is more to integrating complementary medicine than using one treatment with another. In an integrated system, complementary health care approaches are officially recognized and incorporated into all aspects of health as well as the national drug policy. Training and treatment measures are registered and properly regulated. Patients can access both conventional and complementary products and services.

In Equatorial Guinea, Nigeria, Mali, Canada and India, complementary medicine practices are inclusive rather than integrated. This is because the practice is not fully incorporated into all aspects of health. In these countries, complementary medicines are extensively used but are not fully accepted for health care provision. They are also not fully included in the national drug policy.

Many other countries have a "tolerant" system of complementary medicine, which means that allopath is the major system of care and some complementary approaches are allowed under law. South Africa falls in this subcategory.

9.4.9. The challenges

The popularity of complementary and alternative medicine in South Africa has resulted in calls for it to be integrated into the country's health care and medical education systems.

But there are two problems. Firstly, integrative measures into medical and health schools in South Africa are almost non-existent. Linked to this is a scarcity of studies on the integration of these medicines with conventional ones and their effect on patients.

Secondly, there are challenges in deciding what student trainees should be taught. Adding the "selected content" to the intense schedule of medical, pharmacy, nursing and the allied health professions students will pose considerable challenges.

Valuable lessons could be learnt from countries like Cuba where complementary medicine is integrated into training and practice. Medical students are extensively trained in the theoretical and practical aspects of complementary and alternative medicine. Only duly qualified and certified health professionals are allowed to practice with complementary and alternative medicine. This ensures that patients are not exposed to unsafe practices.

9.4.10. Moving towards a single system

South Africa's diversity means there are a variety of complementary health approaches that may differ among different racial, ethnic and cultural groups. This may pose a challenge to inclusion.

As a start, South Africa can create inclusion strategies which will see integration happen over time. These would include quality and efficacy studies and scientific evidence supporting the use of complementary and alternative medicines.

Inclusion strategies may need to be initiated in a specific province, with the full support of government and advisory bodies sanctioned by regulatory authorities. This would focus attention on a smaller area and may limit associated errors.

The strategy would also need to incorporate alternative medicine practices into the training curriculum of medical and health care workers. This would raise awareness of complementary practices among students and expose conventional health practitioners to the benefits and disadvantages.

This strategy would have several benefits, such as successfully incorporating complementary practices into the health system. It would also mean that practitioners could advise patients about medicines and treatments accordingly. Most importantly, it would advance the agenda of health care for all in South Africa.

The survey also indicated that about 60% of the participants do not use supplements or herbs often or do not use them at all, while on the other hand, only 40% has indicated that they often use herbs. This a great concern because it is a fact that more than anything else in our lives, the foods we regularly eat help determine whether or not we will become ill, or remain healthy into older age, Whether vegetables, fruit, meat, oils or grains, foods contain influential substances including antioxidants, phytonutrients, vitamins, minerals, fatty acids, fiber and herbs. The above can be used as medicine to heal diseases and prevent them. Below is case study of clients who consulted in our practice which serves as a practical example of how and when can we use herbs and supplements in our practices;

9.5. Case study 2

9.5.1. Client with cholesterol

- Can be given vitamin c to reduce cholesterol.
- Chromium picolinate lowers cholesterol and balances the LDL to HDL levels.
- Essential fatty acids are quite important to reduce the levels of LDL.
- Cayenne and hawthorn berries are very helpful in bringing down high cholesterol.
- Alfalfa, ginger ginseng and turmeric are very helpful in reducing cholesterol levels.
- Eating fruits such as apples, bananas, carrots and olive oil also helps.

9.5.2. Client with abdominal pains

- 2tsp chamomile, 1tsp rosemary, 1tsp sage. Infuse in 500ml boiling water. Drink a cup full every half an hour.
- Ginger tea made by chopping up 2cm of fresh root ginger into a, mug of hot water. Drink it, it's also soothing.
- Buchu & fennel teas
- Parsley (Avoid during pregnancy)
- Sweet Fennel (Avoid during pregnancy & epilepsy)

9.5.3. Client with abscess

Herbs

- Arnica Cream beneficial
- Burdock root
- Cayenne
- Dandelion
- Echinacea
- Goldenseal
- Red clover
- Yarrow
- Yellow dock
- Drink astralagus or nettle tea.

Extra Supplements

- Vitamin A
- Zinc
- Vitamin C
- Vitamin B complex
- Liquid chlorophyll
- Garlic capsules.

Nutrition

- Increase liquids, especially fruit juices (lemon).
- Avoid dairy products and sugars.
- Eat plenty berries

9.5.4. Client with allergies

Supplements

3x vitamin C 1000mg

2x antioxidant complex

2x multivitamin and multi mineral (providing B6 100mg and zinc

15mg)

Herbs

- Add a small amount of ginseng powder to herbal drinks to overcome the tendency to allergic attacks, such as hay fever.
- Eat the local honey in a cup of warm water with 2 tablespoons of
- Apple cider vinegar to reduce the reaction to allergens.

- Cayenne aids in prevention of infections, it helps ward off colds, sinus infections and sore throats. Elder tones the mucous lining of the nose and throat, increasing their resistance to an infection. The elder flower can be used to treat ear infections, allergies and helps reduce the severity of hay fever attacks.
- Echinacea is a great detoxifier and is also a natural antibiotic which helps to relieve allergies. It has the ability to raise the body's resistance to bacterial and viral infections by stimulating the immune system.
- Nettle is anti-allergenic treating hay fever, asthma and itchy skin conditions. It soothes and improves the mucous condition of the lungs.

Supplements

- Calcium and magnesium reduces stress. Methyl sulfonic methane has antiallergenic properties
- Vitamin B complex is needed for proper digestion and assimilation of nutrients and helps to relieve wheezing and allergy attacks.
- Vitamin C with bioflavonoids protects the body from allergens and Reduces mucous membrane inflammation.
- Potassium is needed for adrenal gland function.
- A multivitamin and mineral complex is important for proper immune function.

9.5.5. Client with anemia

- Hawthorn berry, horsetail, mullein, nettle, red raspberry, shepherd's purse and yellow dock contain iron and are helpful for persons suffering from anemia.

Nutrition

- Beet and carrot juice may be drunk to treat the condition.
- Nettle tea is rich in iron, drink daily.
- Eat apples, apricots, asparagus, bananas, broccoli, egg yolks, kelp, leafy green vegetables, parsley, peas, plums, prunes, purple grapes, raisins, rice, squash, whole grains, oranges, mangos, papayas, strawberries, tomatoes and liver.

Supplements

- Blackstrap molasses contains iron and essential B vitamins
- Folic acid with Biotin is needed for the formation of red blood cells
- Iron to restore iron needed by the body
- Vitamin B12 injection for those suffering from Pernicious anemia
- Vitamin B complex plus extra B5 and B6 is important for red blood

cell production and cellular reproduction.

- Vitamin B6 aids in the absorption of vitamin B12
- Brewer's yeast is rich in all basic nutrients and is a good source of B vitamins

9.5.6. Client asthma

Herbs

- Mullein oil, taken as a tea or fruit juice, has an almost immediate effect.

- Euphorbia helps to control mucus build-up.
- Chamomile tea reduces stress and inflammation in the lungs.
- Drinking turmeric sprinkled in water helps to open the airways.
- Ginkgo biloba seeds may relieve wheezing and lessen phlegm on the chest.

- Nettle's allergenic properties can be helpful in relieving respiratory problems caused by asthma.

- Thyme relieves bronchial spasms and is an expectorant.
- Pau d'arco acts as a natural antibiotic and reduces inflammation.
- Echinacea's allergenic and anti-inflammatory properties are helpful in treating asthma.

- Liquorice has expectorant and soothing properties.

Aromatherapy

- Bergamot and chamomile oils are useful for attacks triggered by stress.

- Inhale the steam of water mixed with a few drops of lavender and eucalyptus oils after an attack to relax and open your air passages.

Nutrition

- The diet should be high in protein, low in carbohydrates.
- Eat more garlic and onions as they inhibit an enzyme which helps cause inflammation.

- Eat fresh fruit and vegetables, nuts, oatmeal, brown rice and whole grains.

- Avoid foods such as beans, broccoli, cauliflower, mushrooms, cabbage, bran and ice cream.

Supplements

- Vitamin A plus beta-carotene is needed for tissue repair and

immunity.

- Vitamin B complex with extra B6 and B12 stimulates the immune system, is helpful in treating allergies and asthma and reduces the

inflammation that occurs in the lungs during an attack.

- Vitamin C with bioflavonoids is needed to protect lung tissue and stop infection.

- Vitamin C also increases airflow through the lungs and reduces inflammation.

- Vitamin D3 is essential for tissue repair.

9.5.7. Client with bladder Infection

Herbs

- An herb traditionally used to support the urinary tract; Cranberry acidifies the urine and prevents bacteria from adhering to bladder

cells.

- Antimicrobials such as Bearberry and Buchu may be effective treatments.

- Birch leaves increases the removal of waste products in the urine.
- Goldenrod is a valuable remedy for urinary tract disorder as it helps flush out the kidneys and bladder

- The diuretic properties of Olive Leaf Concentrate and Corn Silk make it useful in treating cystitis.

- Gravel Root may also be beneficial in the treatment of urinary tract infections such as cystitis.

- Add antiseptic bergamot, lavender and sandalwood to the bath.

Nutrition

- Your diet should contain celery, lots of fluids, parsley and watermelon.
- Avoid citrus fruit, alcohol and caffeine.

Supplements

- Vitamin C has antibacterial effect.
- Acidophilus restores "friendly" bacteria.
- Calcium reduces bladder irritability and acidity in the urine.
- Potassium supplementation is necessary to replace lost potassium due to frequent urination.

The research also showed that 25% prefer using herbs while 35% prefer using drugs/conventional medicine, 40% of them indicated that they prefer using both. This clearly shows that people are getting more and more aware that herbs can play a major role in the primary health care. People across the world have been using herbal medicines since ages. Although there is no scientific backing associated with the use of herbal medicines, individuals have been able to sustain full faith on this remedy which has a history of more than 5000 years for curing various ailments.

There are lots of merits and demerits linked with herbal medicines such as the following;

9.6. Advantages of Herbal Medicines

Herbal medicines are very cheap in comparison to the conventional form of medication. It is something which every pocket can afford, unlike other forms of medication which can create a big hole in your wallet.

Herbal medicines can be consumed without the aid of any kind of prescription. They can be found very easily from a local drug store.

Herbal medicines are known to be more productive in comparison to other forms of medication in curing certain conditions. Unless mixed with other chemical components, they are known to be all natural.

One of the greatest benefits associated with herbal medicine is the non-existence of side effects. Also, they tend to offer long lasting benefits in terms of overall wellness.

Obesity is a growing problem which is known to have hazardous issues on an individual's health. Herbal medicine can help one deal with the problem of obesity very effectively without consuming much time and efforts.

Although the advantages dominate the disadvantages, there are a few risks associated with herbal medicine as well. Let's have a look at the demerits.

9.7. Disadvantages of Herbal Medicines

Herbal medicines are known to be ineffective against serious ailments. Herbal medication cannot cure a broken hand, nor is it able to deal with heart attack related issues as effectively as a conventional doctor.

In some instances, individuals switch to herbal medication without realizing that the symptoms can be linked to a different ailment. Unlike, conventional medication which involves constant monitoring of your health, herbal medicines are taken without prescription which means that in some cases, individual might be undergoing a trial and error process with their medication.

Although herbal medicines have the potential to cure many ailments, the curing period is usually longer in comparison to conventional medication. One needs to have immense patience while undergoing herbal treatment.

Herbal medicines can cause allergic reactions in some cases. Before resorting to herbal medication, you need to ensure that you are not allergic to the particular herb that you will be consuming. Conventional medication can also cause allergic reactions, but they are usually taken upon prescriptions which is why the chances of allergic reactions are less.

Many governments do not approve of any kind of herbal medication. It is usually consumed upon the person's own risk, and when it comes to branded herbal supplements one can't expect any kind of quality assurance.

Admits all the advantages and disadvantages, there is no denying to the fact that the merits of herbal medicines overpower the demerits. It is always advisable to seek help from a good practitioner of herbal medicines to make the most of it.

When considering natural versus conventional medicine, which one is better? The truth is, we should not have to choose. There is always a tendency is to want to see things in black and white. Doing this can make life a lot easier. After all, if you know you like chocolate you won't have to waste as much time distressing over the composition of your next ice-cream cone. But this either-or worldview can also be very limiting. If you look closely, you start to notice that life can't actually be divided so neatly. In reality, there is a lot more grey than brilliant white or midnight black. Unfortunately, People Tend to Fall into Two Camps When it Comes to Medicine as Well either they think Western medicine has all the answers and natural healthcare is a bunch of hocus-pocus, or they think traditional/natural/alternative treatments are the only way to go, and Western medicine is toxic. But the truth is, it should never be an either-or situation. In fact, your long-term health will be better if you work with a team of practitioners who have a variety of expertise, in both natural and conventional treatment modalities. There Is a Time and a Place for both by honing in on how the individual pieces of the human body work, Western medicine now encompasses what was science-fiction just 50 years ago. Drugs have been developed that can pinpoint a molecule and affect how it reacts in the body. Organs can be transplanted. Lifespans have doubled. These accomplishments are nothing short of miraculous. Natural medicine has it's own list of miracles, but it's worldview is based on a vocabulary that sees the bigger picture. Rather than investigating the individual building-blocks of the human body, traditions like Ayurveda, Chinese medicine, and western herbalism are more apt to look at the web that is the whole human. From this holistic standpoint it is easier to understand why a digestive issue might be causing depression, or how a lung imbalance is related to a persistent skin rash. Because of its big-picture perspective, this approach lends itself to finding equilibrium within every aspect of the person. This is in contrast to Western medicine, where the imbalances are seen as issues that need to be removed. Sometimes the body is not strong enough, and will have a much easier time healing if the issue is removed, as is the case with tumors or critically failing organs. In these extreme cases, Western medicine is undoubtedly a smart choice, but it does not have to be the only choice. They Can Work Together When undergoing extreme treatments, like surgery or chemotherapy, the wisest choice of all would be to use a natural treatment alongside the conventional treatment. Natural modalities are especially good at tapping

into the innate healing potential we all carry, and provide the tools we need to better navigate life's complexities. In today's culture, people are too quick to look for an easy solution, to remove the impediment with some drug and ignore the imbalances that brought those symptoms out in the first place. For example, taking an ibuprofen when you have an occasional headache is not necessarily a bad idea, but needing one every day should be a red-flag that something needs to change. Getting blood moving with exercise, making organs function better with good nutrition and herbs, and calming the mind with meditative practices are all necessary components of living a healthy life and preventing imbalances that can cause things like chronic headaches. Study shows that all too often, conventional medicine cannot offer a better solution than pain-killers. On the other hand, it is always a good idea to get things checked out by a medical doctor. When there's an extreme health scare it would be irresponsible to ignore the immense medical advances, science has provided to us, and it's a good idea to get a regular check-up to see what's happening with your internal chemistry. When something big does come up, you don't have to between conventional and alternative treatments.

The survey also dealt with the experience and views of the participants about the **quantum resonance analyzer** machine which use as a testing device in our practice. An overwhelming 90% of the participants have indicated that the device is accurate while only 10% felt it was not accurate.

9.7.1. What is Quantum Magnetic Resonance Analyzer?

The Quantum Magnetic Resonance Analyzer replaces the need for ultrasonic, nuclear magnetic resonance or radiography for various health related conditions. Simply by holding sensors in your palm, health data will be collected within minutes from various body systems. The magnetic resonance analyzer offers new advantages in the field of material analysis. It has been shown that the applicability of such an analyzer exceeds the range of tissue analysis and other medical applications. The magnetic resonance analyzer measures the degree and type of response of a matter under test, and by comparison with reference matter it assists in recognizing deviations from the desired response. Quantum Magnetic Analyzer, Principle of Analysis; The human body is an aggregate of numerous cells, which continuously grow develop, split, regenerate and

die. By splitting up, cells renew themselves. For adults, about 25 million cells are splitting up every second and blood cells are constantly renewing at a rate of about 100 million per minute. In the process of cellular split-up and renewal, the charged bodies of nucleus and extra nuclear electrons as the basis unit of a cell are moving and changing ceaselessly at a high speed as well, emitting electromagnetic waves without interruption. The signals of electromagnetic waves emitted by human bodies represent the specific condition of human body and therefore, different signals of electromagnetic waves will be emitted by the conditions of good health, sub-health, diseases, etc. The conditions of life can be analyzed if such specific electromagnetic wave signals can be analyzed. The quantum analyzer is a new instrument to analyze such phenomenon. The weak magnetic frequency and energy of the human body are collected by holding the sensor, and after amplification by the instrument and treatment by the built-in micro-

processor, the data is compared with the standard quantum resonant spectrum of diseases, nutrition and other indicators incorporated within the instrument to judge whether the sample waveforms are irregular using the Fourier principle approach. Analysis and judgment can thus be made on health condition and main problems of the testee based on the result of waveform analysis, as well as standard protective and curative proposals.

9.7.2. Analysis Items

The method of quantum resonant magnetic analysis is an emerging rapid, accurate and non-invasive spectral testing method and particularly suitable for comparison of curative effects medicine and health products, and check of sub-health conditions. The main analysis items are over 30, including cardiovascular and cerebrovascular conditions, bone mineral density, trace elements, blood lead, rheumatism, lung and respiratory tract, nephropathy, blood sugar, stomach and intestines, liver and gall, cranial nerves, gynecology, prostate, bone disease, the trace elements of selenium, iron, zinc and calcium, etc.

9.7.2.1. Functional Characteristics

Prediction without symptoms: With only 10 or so cells of pathological change, the analyzer can capture the pathological changes of cells and predict the precursor of disease. By taking health-care actions at this moment, you will be enabled to effectively prevent the various chronic diseases.

9.7.2.2. **Speed and accuracy:**

Multiple indicators of your health can be obtained within minutes. This analysis method is designed to save your time, money and energy. The database of the analysis system has been established with scientific methods including Fourier's principles, strict health statistic treatment and demonstration of a large number of clinical cases, leading to high accuracy.

Non-invasive and painless: The analysis will tell you the condition of your health without ultrasonic, nuclear magnetic resonance, radiography or any invasive testing.

Simple and convenient: It is simple in its operation and in general, people will be able to analyze and interpret the result through short-term training. Health checks can be performed in any place and at any time, saving the time of patients. The following is shown in the magnetic analyzer report:

- Basic Physical Quality Analysis
- Blood Sugar Analysis
- Bone Disease Analysis
- Bone Mineral Density Analysis
- Brain Nerve Analysis
- Cardiovascular and Cerebrovascular Analysis
- Gallbladder Function Analysis
- Gastrointestinal Function Analysis
- Gynecology Analysis

- Human Toxin Analysis
- Kidney Function Analysis
- Liver Function Analysis
- Lung Function Analysis
- Pancreatic Function Analysis
- Rheumatoid Bone Disease Analysis
- Trace Elements Analysis (CA+, Fe, Se, Zn, Vitamin, etc.)
- Male sexual function Analysis
- Gynecology Analysis
- Skin Analysis
- Endocrine System Analysis
- Immune System Analysis
- Breast
- Element of human

The research also shows that people think the prices of herbs is fair, 75% of them felt that the price is worth the quality of the service they get in the practice.

9.8. conclusion

The survey was very successful as it has dealt with a variety of issues that directly affects the community of Tembisa. It has also pointed areas where the practice needs to improve. It has clearly indicated that there is a need to educate our people about wellness, this can be possible if government get more involved in ensuring that the primary health care does not confine itself to clinics and hospitals as it is currently but also embark to roadshow where people are engaged in such matters. The survey also pointed out that perhaps government should empower wellness practices; this will help ease the burden which hospitals and clinics are currently having.

The survey also shows that to accommodate true patient-centered care, the focus of our health care system must shift from only treating disease to also creating health and well-being. This requires adopting a new, integrated model that helps people fulfill their own health needs an achievement that will ultimately deliver the cost and quality outcomes that health managers seek.

If a major goal of health care is to help people live with vitality for as long as they can, we must address the factors as many as possible that affect the course of their life-health trajectory. These factors include nutrition and exercise, managing stress and competing priorities, economic forces, and hurdles preventing access to care.

In addition to treating illness, health care's goal must, therefore, be to promote well-being and prevention as well as to provide support in virtually all aspects of people's lives. Such a holistic approach is at the very definition of patient-centered care and requires treating the body, mind and spirit using whatever combination of tools is most appropriate. By helping people fulfill their own health care needs in this way, we can achieve lower cost and higher quality.

All healthcare practitioners should aspire to holistic medicine and try to practice it. Recognizing the 'whole' person in the prevention and treatment of disease may hold the

key to some diagnoses for doctors. It may also allow valuable and important help and guidance to be given to the patient. Patients tend to be more satisfied if a doctor takes a holistic approach, feeling that their doctor has time for them and their problems. However, in General Practice with only 10 minutes allocated per consultation, time constraints may sometimes make this difficult to achieve.

9.9. Interpretation of findings

The need to train wellness practitioners:

Ethics

Concepts

Acts/bills

2. There is a need to develop procedures which cannot only integrate multiple treatments and beliefs about wellbeing but could also aid new counsellors or health practitioners in facilitating their clientele's movement towards maintaining their health.

3. Wellbeing approach---A positive approach towards understanding disease focuses on what is "right" with the client, and how to improve their integrated functioning in society (wellbeing), rather than what is wrong with the client (Seligman, 2000). This positive perspective in understanding wellbeing has long been associated with how counsellors engage with client wellbeing (Seligman, 2000).

4. The mind and body (the internal and external) are not separated, but are rather interactive and integrated in everyday experience of the individual's reality.

5. Social welfare and health care sectors should be integrated to ensure speedy service delivery and avoid unnecessary departments congestion

6. Gaps within the proposed NHI: South African counsellors experience difficulty in situating themselves within their field and treating clientele, as they often work between multiple, (De Chavez et e.l. 2005

7. Lack of knowledge of the ACTS results in misinforming our clients and this may result to illegal counselling

8. Social welfare and health care sectors should be integrated to ensure speedy service delivery and avoid unnecessary departments congestion

9. Gaps within the proposed NHI: South African counsellors experience difficulty in situating themselves within their field and treating clientele, as they often work between multiple, (De Chavez et e.l. 2005

10. Lack of knowledge of the ACTS results in misinforming our clients and this may result to illegal counselling

This dissertation also discovered the need to adopt an integrated approach towards wellbeing, informed by multiple perspectives that are woven together through an understanding of consciousness as a determining factor in mental and physical phenomena (Goswami, 1995). In particular, such an approach is needed in the development of a screening method that could potentially aid counsellors and other health practitioners to screen for distressing patient pathologies such as mood and anxiety disorders in order to ensure appropriate referral. In so doing, this dissertation hopes to aid the renewed focus of the NHI on 'healthcare for all', as well as safeguarding the health of the patients. In order to fully accomplish these goals, such an approach calls for a screening method that takes into account the debilitating effects of 'labelling' (Szasz, 1974). More importantly, the aforesaid calls for the development of an integrated wellbeing screening method, a method which aims to create quality procedures that underscore the need for clients to understand their own place and responsibility of moving towards their own wellbeing.

wellness graduate programs in counselling are lacking and this needs to be addressed especially when it comes to preparing wellness health practitioners students to engage clients in sharing their religious and spiritual concerns, and values (Eck, 2002, p. 269). Eck asked further suggest that clients are often uncomfortable when it comes to sharing about their spiritual and religious values when attending to them. Health practitioners also afraid to explore the area of spirituality.

Souza (2002) established that most health practitioners' students were

uncomfortable when dealing with spiritual issues in counselling, this is due to fearing offending or of being judged personally. Students' opinions differ on whether they view spirituality as negative or positive, based on their own personal experiences with spirituality, and this work negatively in moving forward with the clear understanding on how spiritual counselling should be included (Souza, 2002, p. 214).

Chapter 10

Conclusion and recommendations:(integrated approach) wellbeing, wellness counsellors in welfare sector and alternative medicine.

conclusion

In reviewing the models of wellbeing, the author has noted that there is a similar understanding among them regarding the beliefs, behaviours, and emotions that a person demonstrates and which are considered to be evidence of a person's wellbeing. In exploring this in relation to the models, many have emphasised that these constructs are inextricably intertwined, because the manner in which a person perceives their wellbeing is seen to affect their emotional state, and in turn, the actions they exhibit as presented in the PWS. The author furthers this notion, preferring the idea of virtues which offers a similar understanding, yet greater clarity on how a person's perception or beliefs affects their emotional and behavioural states of wellbeing.

The review of earlier models of wellbeing has also emphasised that a wellbeing philosophy must be able to encompass all aspects that have been seen to relate to wellbeing without the resultant model being exhaustively long. Moreover, it has also stipulated that the philosophy must incorporate measures to assess the person's presenting state of wellbeing before moving on to fully measuring wellbeing, as seen in Hindler's model where immediate stressors can affect the degree to which clients can be led to facilitating their own wellbeing.

These models have also emphasised the necessity to base the method on the idea of wellbeing as a dynamic and changeable concept, which lies within the hands of the client and not the counsellor. An effective integrative philosophy will have to be formulated on the premise of directing clients towards facilitating their own wellbeing, and be explicit in how patient-responsibility is understood so as not to appropriate blame (Tuohima, n.d.). However, greater clarity is needed in developing this model in relation to its ability to be used with mood and anxiety disorders as well as how the conception of virtues can be used to clarify the connection between mind, body, and soul. The author discusses this in the following chapter of the literature review.

Wellness counselors ought to work in diverse community settings designed to provide a variety of counseling, rehabilitation, and support services. Their duties must depend on their specialty, which is determined by the setting in which they work and the community they serve. Although the specific alignment may have an implied scope of practice, wellness counselors frequently are involved with children, adolescents, adults, or families that have multiple issues, such as mental health disorders and addiction, disability and employment needs, school problems or career counseling needs, and trauma. Counselors must recognize these issues in order to provide their clients with appropriate counseling and support.

Rehabilitation wellness counselors help people deal with the personal, social, and vocational effects of disabilities. They counsel people with both physical and emotional disabilities resulting from birth defects, illness or disease, accidents, or other causes. They evaluate the strengths and limitations of individuals, provide personal and vocational counseling, offer case management support, and arrange for medical care, vocational training, and job placement. Rehabilitation counselors' interview both individuals with disabilities and their families, evaluate school and medical reports, and confer with physicians, psychologists, employers, and physical, occupational, and speech therapists to determine the capabilities and skills of the individual. They develop individual rehabilitation programs by conferring with the client. These programs often include training to help individuals develop job skills, become employed, and provide opportunities for community integration. Rehabilitation counselors are trained to recognize and to help lessen environmental and attitudinal barriers. Such help may include providing education, and advocacy services to individuals, families, employers, and others in the community. Rehabilitation counselors work toward increasing the person's capacity to live independently by facilitating and coordinating with other service providers.

wellness counsellors are involved in the mental health counselling work with individuals, families, and groups to address and treat mental and emotional disorders and to promote mental health. They are trained in a variety of therapeutic techniques used to address issues such as depression, anxiety, addiction and substance abuse, suicidal impulses, stress, trauma, low self-esteem, and grief. They also help with job and career concerns, educational decisions, mental and emotional health issues, and relationship problems. In addition, they may be involved in community outreach, advocacy, and mediation activities. Some specialize in delivering mental health services for the elderly. Mental health counselors often work closely with other mental health specialists, such as psychiatrists, psychologists, clinical social workers, psychiatric nurses, and school counselors.

another prevailing challenge in our society today is substance abuse and behavioral disorder which requires extensive counselling and helping people who have problems with alcohol, drugs, gambling, and eating disorders. They counsel individuals to help them to identify behaviors and problems related to their addiction. Wellness counseling can be done on an individual basis, but is frequently done in a group setting and can include crisis counseling, daily or weekly counseling, or drop-in counseling supports. Counselors are trained to assist in developing personalized recovery programs that help to establish healthy behaviors and provide coping strategies. Often, these counselors also will work with family members who are affected by the addictions of their loved ones. Some counselors conduct programs and community outreach aimed at preventing addiction and educating the public. Counselors must be able to recognize how addiction affects the entire person and those around him or her.

The high rate of divorce requires marriage and family therapists who must assist family breakdowns related challenges, principles, and techniques to address and treat mental and emotional disorders. In doing so, they modify people's perceptions and behaviors,

promote communication and understanding among family members, and help to prevent family and individual crises. They may work with individuals, families, couples, and groups. Marriage and family therapy differ from traditional therapy because less emphasis is placed on an identified client or internal psychological conflict. The focus is on viewing and understanding their clients' symptoms and interactions within their existing environment. Marriage and family therapists also may make appropriate referrals to psychiatric resources, perform research, and teach courses in social development and interpersonal relationships.

Access to public information and citizens' participation in the decision-making process of the public administration are most crucial elements of open public administration. In this regard the principle of transparency in public administration involves many other principles that are influencing the process of transformation toward open and good governance. The accomplishment and implementation of this principle involves requires a number of contributing features such as information technology, the commitment of public officials, the consciousness of citizens, efficient public services, proper control, etc. Consequently, the main challenge for any modern and democratic public administration is how to establish a government which is transparent and functional. Because from the modern public administration, citizens anticipate that public officials are on duty to best serve the interests of the public as well as to manage public resources with premeditated decision. Also, modern public administration should inspire citizens' trust as a fundamental instrument for good governance. The value of transparency and accountability in public administration in the last three decades received essential attention, in particular when it comes to the need for governmental reforms vis-à-vis development of societies and requests for more transparency and accountability from public officials. Thus, reformed governance should involve standards for cooperation between administration and citizens in order to promote further rule of law, citizens' participation, accountability, and transparency. The energy to construct an open and transparent administration should be generated from politicians, ministers and other high and middle public officials, civil society and citizens, if a country aims to build a modern public administration and democratic governance. Though, accountability and transparency are essential for both, democratic governance and public administration that serves its citizens. Transparency and accountability inter alia smooth the assessment of the quality of the administrative decision-making process, at the meantime, administrative practice vis-à-vis administrative justice is better harmonized with both domestic and international legal framework. Also, transparency and accountability improve the performance of public administration, as responsibility and transparency must be a push factor towards the improvement of performance. Therefore, constitutional modern democracies should not only guarantee clear rules for access to executive power, but must also ensure the transparent operation of public functions, so that society may know and evaluate governmental management and the performance of civil servants

The South African social welfare system is characterized by the need for the transformation of services and the need for the promotion of service integration among different stakeholders. In the context of the wellness counseling, transformative

processes brought by political reforms that were previously introduced should be improved. It is also clear that there is lack of national participation as a result of government to create inclusive guidelines to its policies. This has resulted in non-societal participation from the marginalized who perceived to be excluded in the planning and implementation processes. The lack of society trust against government as the result of rampant corruption has also caused a mistrust between government and the society. It is also clear that government is now failing to address societal issues by lacking to promote partnership between stakeholders; wellness counseling, religious leaders, local government, social welfare and other government departments.

Social PROBLEMS AND AREAS OF NEED

South Africa, like many other developing countries, is beset by serious social problems that requires a government structured, society driven concerted effort to address. Some of the most pressing social problems include the following:

Lack of healthcare and counselling services and facilities

With a population of almost 60 million, SA is the 25th most populated country in the world with almost half of the people unemployed. This leads to high crime rates and insufficient healthcare facilities. This situation provides the space for wellness counsellors to work in structured and supervised environments including, but not limited to private and government Institutions, schools, Non-Governmental Organisations including Faith Based, Community Based and Not-for-Profit Organisations, the South African Police Service, Counselling Call Centres, Hospitals, Clinics and Support Agencies, Sports Centres, Education and Training facilities, Health and Emergency services and facilities. With insufficient numbers of available healthcare workers and many people that cannot afford to belong to medical aids schemes, wellness workers fulfil a much-needed function by working in a variety of needy contexts, often in environments where mental health professional such as psychologists and social workers are not necessarily accessible to the majority of the population. They make an important contribution to social work in terms of counselling that enables one or more people to go through the process of finding solutions to their concerns or difficulties. Counselling may take various forms, including with individuals, couples, families or domestic units and groups. The Further Education and Training Certificate: Counselling Qualification will allow counsellors to be recognised and will address current national health and social service priorities. Ideally, qualifying learners will operate under supervision.

Lack of dignity, safety and support

The occurrence of domestic violence has always been alarmingly high in South Africa. Though domestic violence is not limited to female members of the family, statistics show that women are most affected by this form of violence. In many domestic violence cases women and girls are often battered and even killed by their partners/relatives. Fear of abandonment often prevents women from reporting violence on themselves. Incest and abuse are most commonly practiced in families where the father is the only source of income, because the entire family is dependent on him. In this situation

fathers subject their daughters or stepchildren to sexual abuse and often the incidents are not reported to the police or sometimes even to their mothers. If the incident is reported to the child's mother, she would often not report it to the police for fear that the father would victimise her or withdraw the resources that keep the family going. This suggests that poverty and bad socio-economic conditions (like unemployment and overcrowding) play an important role in silencing abuse victims. It should be highlighted that women are not only abused by people familiar to them. They are also exposed and vulnerable to abuse by strangers. It is widely (though completely falsely) believed that sexual engagement with a young child or virgin can cure HIV/AIDS. This exacerbates the exploitation of young girls and virgins by strangers and family members alike. In spite of an intensive campaign to discourage people, this disgusting exercise is perpetuated. Women victimised by strangers are mostly those without good infrastructure. In 1996, in an attempt to address the state of affairs, the government introduced the Domestic Violence Act (Act 116), with the objection of providing protection to women against domestic violence and abuse. The Act outlines behaviour that constitutes domestic violence including physical, sexual, verbal, emotional and psychological abuse; stalking, intimidation, harassment, malicious damage or unauthorised access to the complainant's property; as well as other forms of controlling behaviour which may cause harm to the safety, health or wellbeing of the complainant. The Act allows women to approach the court to apply for a protection order against their abusive partners and prohibits an abusive partner to commit any action of domestic violence. Fortunately, many NGO's are stepping in to help relieve the problem. There are vibrant Nongovernmental Organisations, like People Opposing Women Abuse (POWA) and Women Against Women Abuse (WAWA), which were established in 1979 and 1989 respectively, to educate and support female victims of assault and rape. Safety and security are a big issue in South Africa with so many hijacks and murders being committed in black townships and on farms. This underscores the need for trauma counselling where wellness counsellors can partake in interventions. The government has also released a White Paper for Safety and Security. The White Paper provides the means of realising our vision of improving the safety of our citizens.

Poverty

The government aims at social welfare policies and programmes to be developed which will be targeted at poverty prevention, alleviation and reduction and the development of people's capacity to take charge of their own circumstances in a meaningful way. Individuals, families and households are particularly vulnerable to poverty in times of unemployment, ill health, maternity, child-rearing, widowhood, and old age. Disability in a family also increases the impact of poverty. Further, economic crises, political and social changes, urbanisation, disasters or social and political conflict and the displacement of people contribute to, or heighten the distress of poverty. Adequate social protection will be provided for people who are impoverished as a result of these events. Poverty coincides with racial, gender and geographic or spatial determinants, and these will be taken into account in the targeting of programmes. While poverty is widespread throughout South Africa, African people are most affected. Women and children (particularly in female headed households), people with special needs, and

those living in rural areas, informal settlements and on farms, are most at risk and will be assisted. Poverty is often accompanied by additional social problems, such as family disintegration, adults and children in trouble with the law, and substance abuse. It is the combination of economic-mic, social, and emotional deprivation which heightens the vulnerability of poor individuals and families. Appropriate programmes will be implemented to enhance social integration. Support and assistance (such as restoring dignity and self-esteem, the promotion of competence and empowerment programmes) will be provided for individuals and families to assist them to break out of the structural barriers which keep them in poverty. Poverty is often accompanied by low levels of literacy and a lack of capacity to access economic and social resources. The welfare departments' developmental social welfare programmes will build this capacity, facilitate access to resource systems through creative strategies, and promote self-sufficiency and independence. Innovative strategies will be designed for vulnerable individuals and families to increase their capacity to earn a living through employment creation, skills development, access to credit and, where possible, through facilitating the transition from informal to formal employment. Special programmes will address the needs of vulnerable households and help them access both governmental and non-governmental employment programmes. Employment programmes for people with special needs will always be necessary and will be provided. Poverty also places strains on household resources and on family and informal networks, which increase the need for formal social welfare services. Existing family and community networks will be developed and strengthened. Poverty is one of the most important causes of hunger and malnutrition, which contribute to illness and disability. Social welfare departments will appropriate incorporate nutritional objectives and activities into their relevant components. The welfare departments will also collaborate with other government departments to ensure that these programmes are effectively targeted at those who are vulnerable to malnutrition and at the socio-economically deprived in the form of supplementary feeding, public works, capacity building and other developmental programmes which will contribute to household food security. Welfare departments will co-operate with health departments in their supplementary feeding programmes for children and women. The nutritional needs of other vulnerable groups such as the elderly will also be addressed. Structural poverty emanates from the economic, political and social organisation of society. Unjust legislation and inequitable policies and programmes of the past have also contributed to increasing levels of poverty. In view of the structural causes of poverty, an intersectoral response is needed. The Department of Welfare will collaborate with other government departments and nongovernmental organisations and institutions to develop an integrated response to poverty. In view of the widespread rural poverty, a rural development strategy will be developed by the Department of Welfare in consultation with all the relevant role players, which will increase the access of rural people to developmental social welfare programmes. An overarching anti-poverty programme will need to be developed which requires the cooperation between government departments and non-governmental organisations.

Discrimination and lack of equity

All forms of discrimination in the social welfare system will be eliminated in accordance with the Constitution of the Republic of South Africa. Religious, cultural and language rights will be accommodated in accordance with the Constitution. Creative strategies to address racial inequalities will be considered, e. g. taking services to the people; exploring the use of mobile units; bussing people to service points if this is cost-effective; networking between communities to find solutions; strategic planning and change management interventions; mediation and dispute resolution; cross-cultural education; breaking down racial stereotypes, barriers and social distance between groups; and the exchange of resources. National and provincial plans will be devised in consultation with stakeholders to phase out racial discrimination. Such plans will have detailed targets, time frames and monitoring procedures. Minimum criteria for the delivery of welfare services will also be developed. Governmental and non-governmental organizations will create equal opportunities for people with disabilities. Appropriate programmes will be developed to enhance their independence and promote their integration into the mainstream of society. Social welfare policies and programmes will be devised to become more gender sensitive and to address the special needs and problems of women. The national and provincial departments of welfare are committed to providing services while they orient themselves in new directions. The reorientation process will take place alongside the existing system and the new system will be phased in immediately.

Lack of community development

Social workers are involved in community development programmes. Community development strategies will address basic material, physical and psycho-social needs. The community development approach, philosophy, process, methods and skills will be used in strategies at local level to meet needs. The community development approach will also inform the reorientation of social welfare programmes towards comprehensive, integrated and developmental strategies. Community development is multi-sectoral and multi-disciplinary. It is an integral part of developmental social welfare. The focus of community development programmes in the welfare field will be on the following:

(a) The facilitation of the community development process.

(b) The development of family-centered and community-based programmes.

(c) The facilitation of capacity-building and economic empowerment programmes.

(d) The promotion of developmental social relief and disaster relief programmes.

(e) The facilitation of food aid programmes in emergency situations owing to disasters such as floods, fire, civil unrest or drought, or to alleviate acute hunger. Food aid of this nature will be a temporary measure until individuals and households can be incorporated into other social development programmes.

(f) Voluntary participation in social and community programmes will be actively encouraged and facilitated.

(g) Self-help groups and mutual aid support programmes will be facilitated where needed.

(h) Advocacy programmes will be promoted.

(i) The Government will facilitate institutional development with the focus on creating and/or strengthening existing Government institutions and organisations of civil society.

(j) Appropriate public education and non-formal education programmes will be facilitated.

(k) The promotion of community dispute resolution and mediation programmes will be embarked upon where needed. Training programmes will be provided.

(l) The access of local communities to governmental and non-governmental resources to address needs will be facilitated.

(m) Intersectoral collaboration will be promoted, while the separate functions of different sectors and Government departments will be acknowledged. A range of social development workers will be employed to address different needs and problems and to increase human resource capacity, particularly in under-serviced communities and rural areas. Effective training programmes, accreditation systems and the definition of the roles and responsibilities of social workers and other categories of personnel will be developed. There will be scope for some social development workers to perform specialised roles while others will be more generic or development-oriented. A task group will be established to develop volunteer programmes at national and provincial levels. These programmes will be developed in consultation with all stakeholders in order to increase human resource capacity in the delivery of developmental social welfare services and programmes.

Recommendations

From the content of this research, it has been established that various areas of action have been highlighted that will support and enable the various policy makers to better align their practices with regards to the needs of the society, thereby integrating the legislative sector further. In particular, recommendations for implementation of these various areas of action at a high level can be categorized as follows:

• **Structuring policy and related social welfare**: Each individual decision-making organ needs to review their current policy in terms of the feedback provided in this reflection in order to fill the gaps that have been outlined. These gaps derive from various needs identified in the social welfare sector. This step alone will bring a degree of integration into the identified gaps across the sector. This alone will not achieve the ultimate integration and cooperation that is envisaged as part of this reflection objective. In order to achieve a more fundamental level of integration and consensus and public participation in the social welfare sector, the various elements of the policies and how they are interpreted, applied and practiced, will need work-shopping, discussion and agreement of sector practices that can be amended by each legislature

in order to align the practices more closely. It is recommended that government would have the mandate to begin this and cascade any feedback into each legislature's policy framework, manual and templates, into the up-skilling of managers and retraining of key staff to carry these changes through.

Appropriate approach

The social service delivery system is organized along specialist lines. It is fragmented between a number of fields of service, which did not always allow for a holistic approach. While some social workers have received training and practice in community development, the approach to service delivery is still largely rehabilitative, it relies on institutional care and is not preventative and developmental. Welfare services are not accessible and responsive to the needs of all people. There is a lack of personnel to address needs, especially in provinces with large rural areas. Other categories of personnel are underutilized. A significant proportion of existing personnel are not trained in developmental approaches.

Restructuring the partnership between stakeholders to develop a system which is socially equitable, financially viable, structurally efficient and effective in meeting the needs of the most disadvantaged sectors of the population, and to involve communities in planning and the delivery of services.

• **Implementation of the Traditional health Act of 2007**: The implementation of this Act will address some of the discussed challenges speed up the implementations of priorities. The current congestion, poor condition of our public health hospitals, and ignored integrated health system will be addressed by the establishment of wellness counselors within the primary health sector. This in turn could be fed into the Monitoring and Evaluation processes within each of the legislatures thereby enabling better planning and evaluation of current initiatives and help to apply resources optimally.

. Inter-sectorial structural changes

In order to ensure that the proposed inter-sectorial structural changes are effective, the following recommendations should be considered;

i) innovate and pioneer new services and programmes, which, if successful, could be replicated on a wider scale.

ii) identify local needs.

iii) respond speedily, appropriately and flexibly to local needs.

iv) promote grass-roots participation in decision-making and direct service delivery.

v) represent their particular constituencies on structures, such as policy-making and coordinating programmes, at all levels of Government to ensure that interventions are appropriate.

vi) mobilize communities to take action to meet their needs.

viii) co-ordinate action at the local level.

community Participation

Participation of the society and all stakeholders in decision-making on social welfare policies, programs and priorities was not exercised fully and effectively. This resulted in a lack of legitimacy in the welfare system. The following constitutes an approach to best Practice in societal participation:

Societal Participation: It includes initiatives on educating the citizens including campaigns and public consultations (both on how the process should be achieved and on the substance of the act /legislation) through national dialogue.

Representation and Inclusion: An inclusive process will attempt to draw in all key stakeholders to the process. Efforts should be made to reach out to marginalized sectors of society, including women, young people, people with disabilities, ethnic/religious minorities and indigenous groups, older people, poorer socio-economic and disadvantaged groups, and migrants and non-citizens formally resident in the country.

Transparency: one of the biggest enemies of societal active participation is the failure for the state to be transparent; it is common knowledge that in recent times, there is lack of trust between the society and government hence lack of participation is on the rise. Information about processes, appointments, and consultations timelines should be clear.

National Ownership: This principle requires government to go beyond party politics lines. Currently there is lack of national ownership because government fails to convince the citizens that the policies, they are pursuing are national agenda as opposed to party politics. National ownership can be achieved by developing representative governance structures to build up the partnership between Government, organizations in civil society, religious organizations and the private sector.

References

Aainsworth, M., S. Bell, and D. Stayton. 1974. "Infant- Mother Attachment and Social Development: 'Socialization' as a Product of Reciprocal Responsiveness to Signals." In the Integration of a Child into a Social World, edited by M. Richards. New York: Cambridge University Press.

Abercrombie, N. (1980). Class, structure and knowledge. New York: New York University Press.

Ackoff, R. L. (1981). Creating the corporate future. New York: John Wiley.

Adams, T., Bezner, J., & Steinhardt, M. A. (1995). Principle-centeredness: A values clarification approach to wellness. Measurement and Evaluation in Counseling and Development, 28, 139–147. Retrieved from: http://search.proquest.com/docview/618899722?accountid=10422.

Adams, T., Bezner, J., & Steinhardt, M. A. (1997). The conceptualization and measurement of perceived wellness: Integrating balance across and within dimensions, American Journal of Health Promotion, 11(3), 208-218.

Adams, T., Bezner, J., & Steinhardt, M. A. (1998). Construct validation of the perceived wellness survey. Health San Francisco, 14, 212–219. Retrieved from: http://web.ebscohost.com/ehost/detail?sid=86e9d888-a32f-4a82-902e-4f3c7f5dd1f5@sessionmgr4004&vid=2&hid=4214&bdata=JnNpdGU9ZWhvc3QtbGl2ZQ==#db=a9h&AN=1732957\nhttp://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=1732957&site=ehost-live.

Adams, T., Bezner, J., Drabbs, M., Steinhardt, M., & Zambarano, R. (2000). The conceptualization and measurement of spiritual and psychological wellness in a college student population. Journal of American College Health, 48,165-173.

Adams, T., Bezner, J., Garner, L., & Woodruff, S. (1988). Construct validation of the perceived wellness survey. American Journal of Health Studies, 14(4), 212-219.

Adler, F., & Laufer, W. S. (Eds.) (1993). New Directions in Criminological Theory. New Brunswick: Transaction Publishers.

Adler, A. (1954). Understanding human nature. (H. Ansbadur, Trans.). New York: Fawcett. (Original work published 1927).

Agger, B. (1991). Critical theory, poststructuralism, postmodernism: Their sociological relevance. Annual Review of Sociology, 17(1), 105–131.

Aggleton, L. P., Everitt, B. J, Cardinal, R. N., Hall. J., John, A, & Robbins, T. W. (2000). The amygdala: A functional analysis. University of Cambridge, Cambridge, Oxford University Press, p 2-3

Allport, G. W. (1955). Becoming: Basic Considerations for a Psychology of Personality. New Haven, CT: Yale University Press.

American Counseling Association (ACA). (n.d.). Milestones. Retrieved from: http://www.counseling.org/AboutUs/OurHistory/TP/Milestones/CT2.aspx.

American Psychiatric Association (2003). Diagnostic and statistical manual of mental disorders DSM (4th ed., text revision). Washington DC: APA (2000).

Andreas, C., & Andreas, S. (1989). Heart of the mind. Moab, UT: Real People Press.

Andreas, C., & Andreas, T. (1994). Core transformation – Reaching the wellspring within. Moab, UT: Real People Press.

Andreas, S. (1991). Virginia Satir: The patterns of her magic. Palo Alto, CA: Science & and Behaviour Books

Andreas, S. (2002). Transforming yourself: becoming who you want to be. Colorado: Real People Press.

Andreas, S. (2006). Six blind elephants; understanding ourselves and others. Colorado: Real People Press.

Andreas, S., Andreas, C. (1987). Change your mind—and keep the change. Colorado: Real People Press.

Andreas, S., Andreas, C. (1990). Heart of the mind. Colorado: Real People Press.

Andreas, S., Faulkner, C. (1996). NLP: The new technology of achievement. Boston: Nicholas Brealey.

Andrews, F., & Robinson, J. (1991). Measures of subjective well-being. In: Robinson, Shaver and Wrightsman (Eds). Measures of personality and social psychological attitudes. Volume 1. San Diego: Academic Press, 61-114.

Ansbacher, H. L., & Ansbacher, R. R. (Eds.). (1967). The individual psychology of Alfred Adler. New York: Harper & Row.

Antonovsky, A. (1984). The sense of coherence as a determinant of health. In: Matazarro, et al (Eds.). Behavioral health: a handbook of health enhancement and disease prevention. New York: John Wiley, 114-129.

Antonovsky, A. (1979). Health, stress and coping. San Francisco: Jossey-Bass.

Antonovsky, A. (1988). Unraveling the mystery of health: How people manage stress and stay well. San Francisco: Josey-Bass.

Antonovsky, A. (1990). Studying Health vs. Studying Disease. Lecture at the Congress for Clinical Psychology and Psychotherapy, Berlin, 19 February 1990.

Antonovsky, A., (1996). The salutogenic model as a theory to guide health promotion. Health Promotion International, 11(1), 11–18. Retrieved from: http://heapro.oxfordjournals.org/content/11/1/11.abstract.

Ardell, D. (1977). High level wellness strategies. Health Educ, 8(4), 2-4.

Ardell, D. (1977). High level wellness: An alternative to doctors, drugs, and disease. Emmaus, PA: Rodale Press.

Ardell, D. (1982). 14 Days to a wellness lifestyle. Mill Valley, CA: Whatever Publishing.

Ardell, D. (1985). The history and future of wellness. Health Values, 9(6), 37-56.

Ardell, D. (1986). High level wellness. Berkeley, CA: Ten Speed Press.

Ardell, D. (2000). The hierarchy of wellness, Ardell Wellness Report, 1-3.

Ardell, D. (2004). The importance of critical thinking and evidence-based research in the field of wellness. Press release for a paper delivered before the National Wellness Conference, July 12, 2004. Retrieved from: http://www.nationalwellness.org/TheConference2K4/index.php?id=248&id_tier=2030.

Arenhart, J. B., & Krause, D. (2014). From primitive identity to the non-individuality of quantum objects. Studies in History and Philosophy of Science Part B: Studies in History and Philosophy of Modern Physics, 46, 273-282.

Aspect, A., Dalibard, J. & Roger, G. (1982). Experimental test of Bell's inequalities using time-varying analyzers, Physical Review Letters, 49(25), 1804

Atkinson, R. L., Atkinson, R. C., Smith, E. E., & Bem, D. J. (1990). Introduction to psychology. (10th Ed.). USA: HBJ Publishers.

Baird, F. E., & Kaufmann, W. (2008). From Plato to Derrida. Upper Saddle River, NJ: Pearson Prentice Hall.

Bandler, R. (2008). Richard Bandler's guide to trance –formations. Make your life great. Florida: Health Communication, Inc.

Bandler, R., & Grinder, J. (1976). Patterns of the hypnotic techniques of Milton H. Erickson, M.D. Volume 1. Cupertino, CA: Meta Publications.

Bandler, R., & Grinder, J. Satir, F. (1976). Changing with families. Santa Clara, California: Science and Behaviour Books, Inc.

Bandura, A. (1977). Social learning theory. Englewood Cliffs, NJ: Prentice Hall.

Barnes, T. G. (1977). Foundations of electricity and magnetism. 3rd ed. El Paso: Thomas G. Barnes.

Bartrop, R., Lazarus, L., Luckhurst, E., Kiloh, L. G., & Penny, R. (1977). Depressed lymphocyte function after bereavement. The Lancet, 309(8016), 834-836.

Bateson, G., Bateson, M. C. (1988). Angel's fear: Towards an epistemology of the sacred. (Published posthumously) Chicago: University of Chicago Press.

Beck, J. S. (2001). Why distinguish between cognitive therapy and cognitive behaviour therapy?. The Beck Institute Newsletter, February issue.

Becker, C. M., Glascoff, M. A., & Felts, W. M. (2010). Salutogenesis 30 Years Later: Where do we go from here? International Electronic Journal of Health Education, 13, 25-32.

Becker, R. O. (1990). Cross Currents: The promise of electromedicine, the perils of electropollution. New York: St. Martin's Press.

Ben-Sira, Z. (1985), Potency: A stress-buffering link in the coping-stress-disease relationship, Social Science & Medicine, 21(4), 397-406.

Bertalanffy, L. (1972). General system theory. Foundations, development, applications. Braziller: New York.

Bessinger, C. D. (1996). Reflections on reality, healing, and consciousness. Alternative Therapies in Health and Medicine, 2(2), pp.40–45.

Bezner, J. R., & Hunter, D. L. (2001). Wellness perception in persons with traumatic brain injury and its relation to functional independence. Archives of Physical Medicine & Rehabilitation, 82(6).

Bezner, J., Adams, T. (1999). The relationship between physical activity and indicators of wellness. American of Journal of Health Studies. 15(3).

Birks, M., & Mills, J. (2011). Grounded theory: A practicle guide. London: Sage.

Bjorklund, A., & Dunnett, S. B. (2007). Dopamine neuron systems in the brain: An update. Trends in Neurosciences, 30(5).

Blaut, J. M. (2012). The colonizer's model of the world: Geographical diffusionism and Eurocentric history, Guilford Press.

Bradburn, N. (1969). The structure of psychological well-being. Chicago: Aldine.

Brant, S. G. (2009). Russell Ackoff, Einstein of problem solving, has died. [Online] Retrieved from: http://www.huffingtonpost.com/steven-g-brant/russell-ackoff---the-eins_b_341349.html.

Broad, J. (1993). Coping with the mental illness of one's spouse (spousal coping). DAI-B, 53(12), 6218.

Brown, D. (2009). Religion and spirituality in South Africa: New perspectives. Scottsville, South Africa: University of KwaZulu-Natal Press.

Bryant, R. A., Felmingham, K., Kemp, A., Das, P., Hughes, G., & Pedutoa, A. (2008). Amygdala and ventral anterior cingulate activation predicts treatment response to cognitive behaviour therapy for post-traumatic stress disorder. Psychological Medicine, 38, 555-561.

Busha, C. H. & Harter, S. P. (1980). Research methods in librarianship. New York: Academic press.

Butcher, J. N., Perry, J. N., & Atlis, M. M. (2000). Validity and utility of computer-based test interpretation. Psychological Assessment, 12(1).

Cacioppo, J. T., Berntson, G. G., Larsen, J. T., Poehlmann, K. M., & Ito, T. A. (2000). The psychophysiology of emotion, Handbook of Emotions, 2, 173-191.

Callahan, R. J., & Callaghan, J. (1996). Thought Field Therapy (TFT) and trauma: Treatment and theory. Indian Wells, CA: Thought Field Therapy Training Center.

Callaghan, R. J., & Callaghan, J. (2000). Stop the nightmares of trauma. Chapel Hill: Professional Press.

Callaghan, R., & Roger, J. (1985). Five minute phobia cure: Dr. Callaghan's treatment for fears, phobias and self-sabotage. Wilmington: Enterprise Publishing.

Callahan, R., & Trubo, R. (2001). Tapping the healer within: Using thought field therapy. Columbus, OH: McGraw-Hill.

Campbell A., Converse, P., & Rodgers W. (1976). The quality of American life. New York: Russell Sage Foundation.

Campbell, R. E., & Celllini, J. V. (1981). A diagnostic taxonomy of adult career problems. Journal of Vocational Behaviour, 19.

Cappelen, A. W., & Norheim, O. F. (2005), Responsibility in health care: A liberal egalitarian approach. Journal of Medical Ethics, 31(8), 476-480.

Capra, F. (1974). Ecology and Community. Elmwood Quarterly, California, 1-10.

Capra, F. (1976). Modern physics and eastern mysticism. Journal of Transpersonal Psychology, 8(1)

Capra, F. (1982). The turning point. USA: Simon & Shuster.

Carbonell, J. L., & Figley, C. (1999), A systematic clinical demonstration of promising PTSD treatment approaches, Traumatology, 5(1), 6.

Carroll, R. T. (1994). Thought Field Therapy. The Skeptic's Dictionary. [Online] Retrieved from: http://www.skepdic.com/thoughtfield.html.

Carter, C. S. (2004). Effects of formal dance training and education on student performance, perceived wellness, and self-concept in high school students. (Unpublished dissertation) University of Florida.

Carver, C., Pozo, C., Harris, S., Noriega, V., Scheier, ..., & Clark., K. (1993). How coping mediates the effect of optimism on distress: A study of women with early stage breast cancer. J Pers Soc Psychol, 65(2): 375-90.

Chandler, C. K., Holden, J. M., & Kolander, C. A. (1992). Counseling for spiritual wellness: Theory and practice. Journal of Counseling & Development, 71(2), 168-175.

Chandler, K. & Swartzentruber, M. (2011). A correlational study of nature awareness and science achievement. Online Submission. Retrieved from: http://files.eric.ed.gov/fulltext/ED520105.pdf

Chang, S. C., & Chen, C. H. (2005). Effects of music therapy on women's physiologic measures, anxiety, and satisfaction during cesarean delivery. Research in Nursing & Health, 28(6), 453-461.

Chen, Y. (2001). Chinese values, health and nursing. Journal of Advanced Nursing, 36(2), 270-273.

Chiat, M. J. S. (1997). America's religious architecture: Sacred places for every community. New York: John Wiley.

Chomsky, A. N. (1957). Syntactic structures. Republished in 2011 (2nd ed.). Boston: De Gruyter Mouton.

Chomsky, N., & Herman, E. (1988, 2002). Manufacturing consent: The political economy of the mass media. New York: Pantheon.

Church, D. (2009). The treatment of combat trauma in veterans using EFT (Emotional freedom techniques): A pilot protocol. Traumatology,15(4), 55-65.

Clark, D. M., Salkovskis, P. M., Hackmann, A., Wells, A., Ludgate, J., & Gelder, M. (1999). Brief cognitive therapy for panic disorder: A randomized controlled trial. Journal of Consulting and Clinical Psychology, 67(4), 583-589.

Clark, M. E. (1998.) Human nature: What we need to know about ourselves in the twenty-first century. Zygon, 33(4) 645–659.

Coetzee, S. C. (2011). Employee and organisational wellness. Tutorial Letter 202/0/2011. Pretoria: Unisa.

Coetzee, S., Cilliers, F. (2001). Psychofortology: Explaining coping behaviour in organisations. The Industrial-Organisational Psychologist, 38 (4), 62-68.

Cohen S. (1985). Cognitive processes as determinants of environmental stress. Iss Mental Health Nurs, 7(104), 65-81.

Cohen S., & Wills T. A. (1985). Stress, social support, and the buffering hypothesis. Psychol Bull, 98, 310-57.

Cohen S., Sherrod D., & Clark M. (1988). Social skills and the stress-protective role of social support. J Pers Soc Psychol, 50, 963-73.

Compton, W. C (2005). An introduction to positive psychology. Independence, KY: Wadsworth.

Conrad, P. (1994). Wellness as virtue—Morality and the pursuit of health. Culture, Medicine and Psychiatry, 18(3), 385-401.

Cooper, S. E. (1990). Investigation of the lifestyle assessment questionnaire. Measurement and Evaluation in Counseling and Development, 23(2), 83-87.

Corey, L. M. Keyes (2005) Mental Illness and/or Mental Health? Investigating Axioms of the Complete State Model of Health. Journal of Consulting and Clinical Psychology by the American Psychological Association, 73(3), 539 –548.

Costanzo, E. S., Lutgendorf, S. K., Kohut, M. L., Nisly, N., Rozeboom, K., Spooner, S., Benda, J., & Mc Elhaney, J. E. (2004). Mood and cytokine response to influenza virus in older adults. The Journals of Gerontology. Series A, Biological Sciences and Medical Sciences, 59(12), 1328-1333.

Cousins, N. (1979). Anatomy of an illness. New York: W.W. Norton.

Cousins, R. D. (1995). Why isn't every physicist a Bayesian? American Journal of Physics, 63(5), 398.

Covey, S. R. (1992). The seven habits of highly effective people. New York: Simon & Schuster.

Crawford, R. (1984). A cultural account of health. In J. McKinley (Ed.). Issues in the political economy of health care, 198-212. London: Tavistock.

Crose, R., Nicholas, D., Gobble, D., & Frank, B. (1992). Gender and wellness: A multidimensional systems model for counseling. J Couns Dev, 71, 149-56.

Crowell, B. (2011) [2003]. Light and matter. In C. A. Fullerton. Light and Matter. Retrieved from: http://www.lightandmatter.com/html_books/lm/ch11/ch11.html.

Csikszentmihalyi, M. (2004). What we must accomplish in the coming decades. Zygon, 39 (2) 359–366.

Curtis, B. D., & Hurtak, J. J. (2004). Consciousness and quantum information processing: Uncovering the foundation for a medicine of light. The Journal of Alternative and Complementary Medicine, 10(1), 27-39.

Davis, C. D. (2010). Metaphysics and the meaning of life. St. Charles, MO: Three Brothers Press.

de Chavez, A. C., Backett-Milburn, K., Parry, O., & Platt, S. (2005). Understanding and researching wellbeing: Its usage in different disciplines and potential for health research and health promotion. Health Education Journal, 64(1), 70-87.

Degges-White, K. M., & Coope, R. H. (1998). The happy personality: A meta-analysis of 137 personality traits and subjective well-being. Psychological Bulletin, Sep. 124(2),197-229.

Degges-White, S. E., Myers, J. E., Adelman, J. U., & Pastoor, D. D. (2003). Examining counseling needs of headache patients: An exploratory study of perceived stress and wellness. Journal of Mental Health Counseling, 25, 271-290.

Descartes, R. (1989). Passions of the soul. Indianapolis,Idiana: Hackett Publishing.

Dey, I. (2003). Qualitative data analysis: A user friendly guide for social scientists. New York: Taylor & Francis Group.

Dey, I. (2003). Qualitative data analysis: A user friendly guide for social scientists. New York: Taylor & Francis Group.

DHEW (PHS). (1979). Healthy people: The surgeon general's report on health promotion and disease prevention. Publication no. 79-55071. USA: United States Public Health Service.

Diener, E. (1984). Subjective well-being. Psychol Bull, 95(3), 542-75.

Diener, E., & Chan, M. Y. (2011). Happy people live longer: Subjective well-being contributes to health and longevity. Applied Psychology: Health and Well-Being, 3(1), 1-43.

Diener, E., & Seligman, M. E. (2002). Very happy people. Psychological Science, 13(1), 81-84.

Diener, E. D., Emmons, R. A., Larsen, R. J., & Griffin, S. (1985). The satisfaction with life scale. Journal of Personality Assessment, 49(1), 71-75.

Dienstbier, R. A. (1989). Arousal and physiological toughness: Implications for mental and physical health. Psychological Review, 96(1), 84.

Diepold, J. H., & Goldstein, D. (2008). Thought field therapy and QEEG changes in the treatment of trauma: A case study. Traumatology, 15, 85 – 93.

Dilts, R. (1983). Roots of neuro-linguistic programming. Capitola, CA: Meta Publications.

Dilts, R. (1990). Changing belief systems with NLP. Capitola, CA: Meta Publications,

Dilts, R. (2001). New Design NLP. [Online] Retrieved from: http://www.nlpu.com/NewDesign/NLPU_MasterTrainer.html.

Dilts, R. (2011). What is NLP? NLP University. [Online] Retrieved from http://www.nlpu.com/NewDesign/NLPU_WhatIsNLP.html. [Accessed 27.12.2011].

Dilts, R., & DeLouzier, J. (2000). Encyclopedia of systemic neuro-linguistic programming and new coding. Los Angeles: NLP University Press.

Dilts, R., DeLouzier, J. (2011). NLP II The next generation. Enriching the study of the structure of subjective experience. Capitola, CA: MetaPublications.

Dilts, R., Epstein, T., & Dilts, R. (1991). Tools for dreamers. Capitola, CA: Meta Publications.

Dilts, R., Grinder., J., Bandler, R. & DeLozier, J. (1980) Neuro-linguistic programming: volume 1. The study of the structure of subjective experience. Capitola,CA: Meta Publications. (DSM-IV-TR, as cited by APA, 2000).

Dilts, R., Hallbom, T., & Smith, S. (1990). Beliefs: Pathways to health & well-being. Portland. Metamorphous Press.

Division 17. (n.d.). Positive Psychology. A Section of the Division of Counseling Psychology (17) of the American Psychological Association. [Online] Retrieved from: http://www.div17pospsych.com/.

Doherty, M. E., Mynatt, C. R., Tweney, R. D. & Schiavo, M. D. (1979). Pseudodiagnosticity. Acta Psychologica, 43(2), 111-121.

Doherty, M. E., Mynatt, C. R., Tweney, R. D., & Schiavo, M. D. (1979). Pseudodiagnosticity. Acta Psychologica, 43(2), 111-121.

Dolbier, C. L., Soderstrom, M., Steinhardt, M. A. (2001). The relationships between self-leadership and enhanced psychological, health, and work outcomes. Journal of Psychology, 135(5), 469-85.

Du Plessis, E., & Human, S. P. (2007). The art of the Delphi technique: Highlighting its scientific merit. Health SA Gesondheid, 12(4), 13-24.

Dunlop, D. J., Özdemir, Özden (1997). Rock Magnetism: Fundamentals and Frontiers. Cambridge Univ. Press. ISBN 0-521-32514-5.

Dunn, H. (1961). High level wellness. Washington D.C.: Mt. Vernon.

Dunn, H. L. (1957). Points of attack for raising the levels of wellness. Journal of the National Medical Association, 49(4), 225-235, 211.

Dunn, H. L. (1959). High-level wellness for man and society. American Journal of Public Health, 49(6), 786-792.

Dunn, H. L. (1959b). What high-level wellness means. Canadian Journal of Public Health, 50(11), 447-457.

Dunn, H. L. (1977). What high level wellness means. Health Values: Achieving High Level Wellness, 1, 9–16.

Dusek, J. A. Otu, H. H., Wohlhueter, A. L., Bhasin, M., Zerbini, L. F., Joseph, M. G., … Libermann, T. A. (2008). Genomic counter-stress changes induced by the relaxation response. PLoS ONE, 3(7), e2576.

Einstein, A. (1995). Essential Einstein. Pomegranate Artbooks.

Einstein, G., & Shildrick, M. (2009), The postconventional body: Retheorising women's health. Social Science & Medicine, 69(2), 293-300.

Ellis, J., & Smith, P. (1991). Spiritual well-being, social desirability and reasons for living: Is there a connection? Intl J Soc Psychol, 37(1), 57-63.

Ellison, C. (1983). Spiritual well-being: Conceptualization and measurement. J Psychol Theol. 11(4), 330-40.

Els, D. (2012). Wellness in South Africa. International Connection: April 2012, National Wellness Institute. Retrieved from: http://www.nationalwellness.org/index.php?id_tier=128&id_c=442.

Emde, R. N. (1988). Development terminable and interminable: Innate and motivational factors from infancy. The International Journal of Psychoanalysis, 49(1), 71-75.

Emmons, R. A. (1999). The psychology of ultimate concerns: Motivation and spirituality in personality. New York: The Guilford Press.

Erickson, M., & Rossi, E. L. (Ed.) (1980a). The collected papers of Milton H. Erickson on hypnosis. Vol. I. The nature of hypnosis and suggestion. New York: Irvington.

Erickson, M., & Rossi, E. L. (Ed.). (1980b). The collected papers of Milton H. Erickson on hypnosis. Vol. II. Hypnotic alteration of sensory, perceptual and psychophysical processes. New York: Irvington.

Erlandson, D. A., Harris, E. L., Skipper, B. L., & Allen, S. D. (1993). Doing naturalistic inquiry. Newbury Park, CA: Sage.

Erskine, R. G., & Moursund, J. P. (2011). Integrative psychotherapy in action. London: Sage.

Eysenck, H. (1993). Prediction of cancer and coronary heart disease mortality by means of a personality inventory: Results of a 15-year follow-up study. Psychol Rep, 72(2), 499-516.

Fazio, A. A. (1977). Concurrent validational study of the NCHS General Well-Being Schedule. DHEW Publication Number (HRA), 2(73), 78-1347.

Fee, E., & Brown, T. (2002). John Harvey Kellogg, MD. Health reformer and Antismoking crusader. American Journal of Public Health, 92(6) 935.

Feinstein, D. (2009). Controversies in Energy Psychology. Energy Psychology: Theory, Research, Treatment, 1(1), 45-56.

Fendt, J., & Sachs, W. (2007). Grounded theory method in management research: Users' perspectives. Organizational Research Methods, 11, 430–455.

Fisch, R. (1988). Training in the brief therapy model. In H. A. Liddle (Ed.). Handbook of family therapy training and supervision. New York: Guilford Press.

Fisch, R., Weakland, J. H., & Segal, L. (1982) Tactics of change - Doing therapy briefly. San Fransico: John Wiley.

Fordyce, M. (1986). The PSYCHAP Inventory: A multi-scale to measure happiness and its concomitants. Soc Ind Res, 18, 1-33.

Fosha, D. (2004). Nothing that feels bad is ever the last step: The role of positive emotions in experiential work with difficult emotional experiences, Clinical Psychology & Psychotherapy, 11(1), 30-43.

Frankenhaeuser, M. (1991). The psychophysiology of workload, stress, and health: Comparison between the sexes., Annals of Behavioral Medicine,13(4), 197-204.

Frederickson, B. L. (2005). The broaden-and-build theory of positive emotions. In: F. A. Huppert, N. Baylis, & B. Keverne (Eds). The science of well-being. Oxford: Oxford University Press.

Fylkesnes, K., & Forde, O. (1991). The Tromso Study: Predictors of self-evaluated health-has society adopted the expanded health concept? Soc Sci Med, 32(2), 141-46.

Garbarini, F., & Adenzato, M. (2004). At the root of embodied cognition: Cognitive science meets neurophysiology. Brain and Cognition, 56(1), 100-106.

Gendlin, E. (1981). Focusing (rev. ed.). New York: Bantam.

Gerber, R. (1996). Vibrational medicine. Rochester, Vermont: Bear.

Gerber, R. (2000). Vibrational medicine for the 21st century.Rochester, Vermont: Piatkus.

Gerber, R. (2001). A practical guide to vibrational medicine. Rochester, Vermont: Harper Colllins.

Gerber, R. (2001). Vibrational medicine: The #1 handbook of subtle-energy therapies. Vermont: Bear and Company.

Germer, C. K. (2005). Teaching mindfulness in therapy. Mindfulness and Psychotherapy, 113-129.

Gibson, D. M., & Myers, J. E. (2006). Perceived stress, wellness, and mattering: A profile of first-year citadel cadets. Journal of College Student Development, 47(6).

Gillick, M. (1984). Health promotion, jogging, and the pursuit of the moral life. Journal of Health Politics, Policy and Law, 9, 369-87.

Gingerich, W. J., & Eisengart, M. A. (2000). Solution-Focused Brief Therapy: A Review of the Outcome Research. Family Process, 39, 477–498.

Glaser, R., & Kiecolt-Glaser, J. K. (2005). Stress-induced immune dysfunction: implications for health. Nature Reviews Immunology, 5(3), 243-251.

Gleick, J. (1988). Chaos - Making a new science. London: Penguin.

Goldstein, J. L., & Brown, M. S. (1973). Familial hypercholesterolemia: Identification of a defect in the regulation of 3-Hydroxy-3-Methylglutaryl coenzyme A reductase activity associated with overproduction of cholesterol. Proceedings of the National Academy of Science, USA, 70 (10), 2804–2808.

Goleman, D. (1996). Emotional Intelligence. Great Britain: Bloomsbury.

Goodwin, I. C. (2009). The relationship between perceived wellness and stages of change for exercise among rural African American women. Doctoral Dissertation, Georgia State University.

Gordon, D., & Meyers-Anderson, M. (1981). Phoenix: Therapeutic patterns of Milton H. Erickson. Cupertino, CA: Meta Publications.

Goswami, A. (2004). The Quantum Doctor. Boston: Jaico Publishing House.

Goswami, A., Reed, R. E, & Goswami, M (1995). The self-aware universe: how consciousness creates the material world. Penguin Putman. New York.

Government Gazette. (2011). No R. 704, 2011. [Online] Retrieved from: http://greengazette.co.za/.

Government social welfare white paper. (2014). https://www.gov.za/sites/default/files/gcis_document/201409/whitepaperonsocialwelfare0.pdf

Greenberg, J. (1985). Health and wellness: A conceptual differentiation. J Sch Health, 55(10), 403-06.

Greenberg, L. S., Watson, J. C., Elliot, R., & Bohart, A. C. (2001), Empathy. Psychotherapy: Theory, Research, Practice, Training, 38(4), 380.

Greenberg, L., & Watson, J. (1998). Experiential therapy of depression: Differential effects of client-centered relationship conditions and process experiential interventions. Psychotherapy Research, 8(2), 210-224.

Gribbin, J. (2002). Science: A history 1543–2001. London: Penguin Books.

Grinde, B. (2002). Happiness in the perspective of evolutionary psychology. Journal of Happiness Studies, 3(4), 331–354.

Grinde, B. (2005). How can science help religion toward optimal benefit for society? Zygon, 40(2), 277–288.

Grinder, J., & DeLozier, J. (1987). Turtles all the way down. Colorado: Real Press.

Hale, T. (2005). What is the connection between spirituality and medicine? [Online] Retrieved from: http://www.merrynjose.com/artman/publish/article_450.shtml.

Hall, L. M., & Bodenhamer, B. G. (2008). The user's manual for the brain. Wales, UK: Crown House.

Hancock, T. (1986). Lalonde and beyond: Looking back at a new perspective on the health of Canadians. Health Promotion International, 1(1,) 93-100.

Hanson, N. R. (1959). Copenhagen interpretation of quantum theory. American Journal of Physics.

Harari, M. J, Waehler, C. A, Rogers, J. R. (2005). An empirical investigation of a theoretically based measure of perceived wellness. Journal of Counseling Psychology. 52(1), 93-103.

Harrop, E., Addis, S., Elliott, E., &Williams, G. (nd). Resilience, coping and salutogenic approaches to maintaining and generating health: A review. Ardiff Institute of Society, Health and Ethics.

Hattie, J. A., Myers, J. E., & Sweeney, T. J. (2004). A factor structure of wellness: Theory, assessment, analysis, and practice. Journal of Counseling & Development, 82, 354-364.

Haunschild, A. (2003). Managing employment relationships in flexible labour markets: The case of German repertory theatres, Human Relations, 56(8), 899-929.

Hawking, S. W. (1988). A brief history of time: from the big bang to black holes. London: Bantam Books.

Hays, P. A. (2001). Addressing cultural complexities in practice: A framework for clinicians and counselors, pp. 111-127. Washington, DC, US: American Psychological Association, vii, 239 pp. http://dx.doi.org/10.1037/10411-007

Helms, J. E. (1992). Why is there no study of cultural equivalence in standardized cognitive ability testing? American Psychologist, 47(9), 1083.

Herbert, N. (1987). Quantum Reality: Beyond the new physics. New York: Random Books.

Herl, H. E., O'Neil Jr., H.F., Chunga G. K. W. K., & Schacter, J. (1999). Reliability and validity of a computer-based knowledge mapping system to measure content understanding. Computers in Human Behavior, 15(3-4).

Herlitz, J., Wiklund, I., Caidahl, K., Hartford, M., Haglid, M., Karlsson, B., Sjöland, H., & Karlsson, T. (1998). The feeling of loneliness prior to coronary artery bypass grafting might be a predictor of short-and long-term postoperative mortality. European Journal of Vascular and Endovascular Surgery, 16(2), 120-125.

Hermon, D. A., & Hazler, R. J. (1999). Adherence to a wellness model and perceptions of psychological well-being. Journal of Counseling & Development, 77(3), 339.

Hettler, B. (1984). Wellness: Encouraging a lifetime pursuit of excellence. Health Values, 8(4), 13-17.

Hettler, B. (1998). The past of wellness. Retrieved from: www.hettler.com/History/hettler.htm.

Hettler, W. (1984). Wellness: Encouraging a lifetime pursuit of excellence. Health Values, 8(4), 13-17.

Hey, W. T, Calderon, K. S., & Carroll, H. (2006). Use of body-mind-spirit dimensions for the development of a wellness behavior and characteristic inventory for college students. Health Promotion Practice, 7(1).

Heylighen, F. & Joslyn, C. (1992). What is systems theory? [Online] Retrieved from: http://pespmc1.vub.ac.be/SYSTHEOR.html.

Hillian, R. (2004). Galileo Galilei: Father of modern science. New York: The Rosen Publishing Group.

Hjelle, L. A., & Ziegler, D. J. (1992). Personality theories: Basic assumptions, research, and applications. New York: McGraw-Hill Book Company.

Hölzel, B. K., Ott, U., Gard, T., Hempel, H., Weygandt, M., Morgen, K., & Vaitl, D. (2007). Investigation of mindfulness meditation practitioners with voxel-based morphometry. Social Cognitive and Affective Neuroscience, 3(1),55–61.

Holmes, L. (2003). Mental Health. [Online] Retrieved from: http://mentalhealth.about.com/cs/psychotherapy/a/psychotherapy.htm.

Hölzel, B. K., Ott, U., Hempel, H., Hackl, A., Wolf, K., Stark, R., & Vaitl, D. (2007), Differential engagement of anterior cingulate and adjacent medial frontal cortex in adept meditators and non-meditators. Neuroscience Letters, 421(1), 16-21.

HPCSA (2011) Professional conduct and ethics. [Online] Retrieved from: www.hpcsa.co.za. [Accessed 13 August, 2011].

HPCSA. (2011). Professional Board of Psychology. [Online] Retrieved from: http://www.hpcsa.co.za/board_psychology.php.

Hui, K. K. S., Liu, J., Marina, O., Napadow, V., Haselgrove, C., Kwong, K. K., & Makris, N. (2005). The integrated response of the human cerebro-cerebellar and limbic systems to acupuncture stimulation at ST 36 as evidenced by fMRI. NeuroImage, 27, 479 – 496.

Hunt, C. P., & Moskowitz, B. P. (1995). Magnetic properties of rocks and minerals. In T. J Ahrens, Rock physics and phase relations: A handbook of physical constants. 3. Washington, DC: American Geophysical Union, pp. 189–204.

Huppert, F. A. (2005). Positive mental health in individuals and populations. In: F. A Huppert, N. Baylis, & B. Keverne (eds), The science of well-being. Oxford: Oxford University Press.

Idler, E., & Angel, R. (1990). Self-rated health and mortality in the NHANES1 epidemiologic follow-up study. Am J Pub Health, 80(4), 446-452.

Idler, E., & Kasl, S. (19910. Health perceptions and survival, do global evaluations of health status really predict mortality? J Gerontol, 46(2), S55-65.

Illing, K. (1999). Der Gesundheitstourismus. Wellnes als Alternative zur traditionellen Kur? Berlin: TDC e. Kfm.

Institute of Transpersonal Psychology. (n.d.). What is transpersonal psychology? [Online] Retrieved from: http://www.itp.edu/about/transpersonal.php.

Jahoda, M. (19580. Current concepts of positive mental health. New York: Basis Books.

James, T. (2004). The accelerated Neuro-Linguistic Programming master practitioner certification training. [Online] Retrieved from: http://www.nlp.com.

James, W. (1902). The varieties of religious experience. Electronic edition prepared by the University of Virginia Library Electronic Text Centre, 1996. Retrieved from: http://etext.lib.virginia.edu/toc/modeng/public/JamVari.html.

Jasnoski, M., & Schwartz, G. A. (1985). Synchronous systems model for health. Am Behav Sci, 28(4), 468-485.

Jewell, D. V. (2005). The role of questionnaires in health promotion programs that emphasize regular physical activity or fitness. Cardiopulmotiary Physical Therapy Journal, 16(1).

Johnson, K. (2010). NASM Elite Trainer. [Online] Retrieved from: http://www.3-fitness.com.

Jones, A. J. (1934). Principles of guidance. (2nd ed.). New York: McGraw-Hill.

Joseph, A. (2010). Cognitive Behavioural Therapy: Your route out of perfectionism, self-sabotage and other everyday habits. Sussex: John Wiley.

Kammann, R., & Flett, R. (1983). Affectometer 2: A scale to measure current level of general happiness. Aus J Psychol, 35(2), 259-65.

Kaplan, G., & Camacho, T. (1983). Perceived health and mortality: A nine-year follow-up of the human population laboratory cohort. Am J Epidemiol, 117(3), 292-304.

Kaplan, G., Salonen, J., Cohen, R., Brand, R., Syme, L., & Puska, P. (1988). Social connections and mortality from all causes and from cardiovascular disease: Prospective evidence from eastern Finland. Am J Epidemiol, 128(2), 370-380.

Kaptchuk, T. J. (2002). The placebo effect in alternative medicine: Can the performance of a healing ritual have clinical significance? Annals of Internal Medicine, 136(11), 817–825.

Kasschau, R. A. (1995). Understanding Psychology. New York: McGraw-Hill.

Kaufmann, M. (1963). High-level wellness: A pertinent concept for the health professions. Mental Hygiene, 47, 57-62.

Kayne, R. (2012). What are biophotons? In L. S. Wynn (ed.), Conjecture Corporation, [Online] Retrieved from: http://www.wisegeek.com.

Kellogg, J. H. (1932). How to have good health through biologic living. Battle Creek, MI: Modern Medicine Publishing Company.

Kemper, K. J., & Danhauer, S. C. (2005). Complementary and alternative medicine. Music as Therapy, 98(3), 282-288.

Ketz, K., & Israel, T. (2002). The relationship between women's sexual identity and perceived wellness. Journal of Bisexuality, 2(2/3),223-238.

Keverne, E. B. (2005). Understanding well-being in the evolutionary context of brain development. In: F.A. Huppert, N. Baylis, & B. Keverne (Eds). The science of well-being. Oxford: Oxford University Press.

Keyes, C. L. M. (2002). The mental health continuum: From languishing to flourishing in life. Journal of Health and Social Behavior, 43, 207– 222.

Keyes, C. L. M. (2003a). Complete mental health: An agenda for the 21st century. In C. L. M. Keyes & J. Haidt (Eds.), Flourishing: Positive psychology and the life well-lived (pp. 293–312). Washington, DC: American Psychological Association.

Keyes, C. L. M. (2003b). Promoting a life worth living: Human development from the vantage points of mental illness and mental health. In R. M. Lerner, F. Jacobs, & D. Wertlieb (Eds.), Promoting positive child, adolescent, and family development: A handbook of program and policy innovations, l(4), 257–274. Thousand Oaks, CA: Sage.

Keyes, C. L. M. (2004). The nexus of cardiovascular disease and depression revisited: The complete mental health perspective and the moderating role of age and gender. Aging and Mental Health, 8, 266 –274.

Keyes, C. L., & Lopez, S. J. (2002). Toward a science of mental health. Handbook of positive psychology, 45-59.

Kibble, T. W. B., & Berkshire, F. H. (2004). Classical mechanics. (5th ed.). London: Imperial College Press.

Kiecolt-Glaser, J. K., Loving, T. J., Stowell, J. R., Malarkey, W. B., Lemeshow, S., Dickinson, S. L., & Glaser, R. (2005). Hostile marital interactions, proinflammatory cytokine production, and wound healing. Archives of General Psychiatry, 62(12), 1377-1384.

King, M., Davidson, O., Taylor, F., Haines, A., Sharp, D., & Turner, R. (2002). Effectiveness of teaching general practitioner skills in brief cognitive behaviour therapy to treat patients with depression: Randomised controlled trial. BMJ, 324(April).

Kinney, C. K., Rodgers, D. M., Nash, K. A., & Bray, C. O. (2003). Holistic healing for women with breast cancer through a mind, body, and spirit self-empowerment program. Journal of Holistic Nursing, 21(3), 260-279.

Kitayama, S., & Markus, H. R. (eds) (1997). Emotion and culture: Empirical studies of mutual influence. Washington DC: American Psychological Association.

Klein, H., Tatone, C., & Lindsay, N. (1989). Correlates of life satisfaction among military wives. J Psychol, 123(5), 465-75.

Kleinert, S., & Horton, R. (2009). South Africa's health: Departing for a better future? The Lancet, 374(9692), 759-760.

Knekt, P., Lindfors, O., Laaksonen, M. A., Raitasalo, R., Haaramo, P., & Järvikoski, A. (2008). Effectiveness of short-term and long-term psychotherapy on work ability and functional capacity: A randomized clinical trial on depressive and anxiety disorders. Journal of Affective Disorders, 107(1-3), 95-106.

Kobasa, S. (1979). Stressful life events, personality, and health: An inquiry into hardiness. J Pers Soc Psychol, 37(1), 1-11.

Kobasa, S. C., Maddi, S. R., & Kahn, S. (1982). Hardiness and health: A prospective study. Journal of Personality and Social Psychology, 42(1), 168.

Kohut, M., Martin, A., Senchina, D., & Lee, W. (2005). Glucocorticoids produced during exercise may be necessary for optimal virus-induced IL-2 and cell proliferation whereas both catecholamines and glucocorticoids may be required for adequate immune defense to viral infection. Brain, Behavior, and Immunity, 19(5), 423-435.

Kolb, D. A. (1984). Experiential learning: Experience as the source of learning and development. Englewood Cliffs, NJ: Prentice-Hall.

Keyes, C. L. M., & Lopez, S. J. (2002). Toward a science of mental health: Handbook of positive psychology, 45-59.

Kozma, A., & Stones, M. (1978). Some research issues and findings in the study of psychological well-being in the aged. Can Psychological Rev, 19(3), 241-49.

Kozma, A., & Stones, M. (1980). The measurement of happiness: Development of the Memorial University of Newfoundland scale of happiness (MUNSH). Journal of Gerontology, 35(6), 906-12.

Krippner, S., & de Carvalho, A. P. (1998). Sonhos exóticos. São Paulo: Summus Editorial.

Kumar, M. (2009). Quantum. UK: Icon Books.

Lafferty, J. A. (1979). Credo for wellness. Health Education, 10(5), 10-11.

Lalonde, M. (1974). A new perspective on the health of Canadians. A working document. Ottawa: Government of Canada.

Langer, E., & Rodin J. (1976). The effects of choice and enhanced personal responsibility for the aged: A field experiment in an institutional setting. J. Pers. Soc. Psychol, 34(2), 191-98.

Lanigan, R. (2011). Schutzian Research: A yearbook of worldly phenomenology and qualitative social science. Volume 3. Special issue: Phenomenology of the human sciences. USA: Zeta Books.

Larson, J. S. (1999). The measurement of health concepts and indicators. Westport. CT: Greenwood.

Lawton, M. (1975). The Philadelphia geriatric center morale scale: A revision. Journal of Gerontology, 30(1), 85-89.

Lawton, M. (1990). Residential environment and self-directedness among older people. Am Psychol, 45(5), 638-40.

Lazarus, R. S. (1999). Stress and emotion: A new synthesis. New York: Springer.

Lee, C., Ashford, S. & Jamieson, L. (1993). The effects of Type A behavior dimensions and optimism on coping strategy, health and performance. J Org Behav, 14, 143-57.

Lee, Y. (1998). Critique of austins health protection and health promotion model. Theraputic RecreationJjournal, Second quarter, 118-123.

Levine, P. A. (1997). Waking the tiger: Healing trauma: The innate capacity to transform overwhelming experiences. Berkeley, CA: North Atlantic Books.

Levitt, M., Clark, M., Rotton, J., & Finley, G. (1987). Social support, perceived control, and well-being: A study of an environmentally stressed population. Intl J Aging Hum Dev, 25(4), 247-58.

Lewis, A. J., Dennerstein, M., & Gibbs, P. M. (2008). Short-term psychodynamic psychotherapy: Review of recent process and outcome studies. Australian & New Zealand Journal of Psychiatry, 42(6), 445-55.

Lipton, B. (2005). The biology of belief. USA: Hay House.

Lipton, B. H. (2008). The biology of belief: Unleashing the power of consciousness, matter, and miracles. New York: Hay House.

Lipton, B., & Bhaerman, S. (2010). Spontaneous evolution. USA: Hay House.

Loman, S. & Merman, H. (1996). The KMP: A tool for dance/movement therapy. American Journal of Dance Therapy, 18(1), 29-52.

Lowman, R. L. (1996). Work dysfunctions and mental disorders. In K. R. Murhpy (Ed.), Individual differences and behavior in organizations. San Francisco: Jossey-Bass.

Loyd, A., & Johnson, B. (2011). The healing code. London: Hodder & Stoughton.

Lydick, E., Cook, K., Turpin, J., Melton, M., Stine, R., & Byrnes, C. (1998). Development and validation of a simple questionnaire to facilitate identification of women likely to have low bone density. The American Journal of Managed Care, 4(1), 37-48.

Macknik, S., & Martinex-Conde, S. (2011). Sleights of mind. London: Profile Books.

Makinson, L., & Myers, J. E. (2003). Wellness: An alternative paradigm for violence prevention. Journal of Humanistic Counseling, Education and Development, 42, 165-177.

Mareno, N., & James, K. S. (2010). Further validation of the body-mind-spirit wellness behavior and characteristic inventory for college students. Southern Online Journal of Nursing Research, 10(4), Art. 5.

Marshall, G. N., Wortman, C. B., Vickers, R. R., Kusulas, J. W., Hervig, L. K. (1994). The five-factor model of personality as a framework for personality-health research. Journal of Personality and Social Psychology, 67(2), 278-286.

Martin, A. E., Senchina, D. S., Lee, W., Cunnick, J. E., Janke, B. H., & Kohut, M. L. (2005). # 96 Exercise reduces viral burden and enhances innate and adaptive immune responses to influenza infection in aged mice. Brain, Behavior, and Immunity, 19(4), 50.

Martin, C. M., & Peterson, C. (2009). The social construction of chronicity: A key to understanding chronic care transformations. Journal of Evaluation in Clinical Practice, 15(3), 578–585.

Martin, E. P. Seligman, Mihaly Csikszentmihalyi. (2010). Positive psychology: Introduction. January 2000 American Psychologist, 55(1). 5 14 DOI: 10.1037//0003-066X.55.1.5.

Maslow, A. (1954). Motivation and personality. New York: Harper.

Maslow, A. H. (1943). A theory of human motivation. Psychological Review, 50(4).

Mattessich, R. (1982). The systems approach: Its variety of aspects. Journal of Am. Soc. Inf. Sci., 33, 383–394.

McMillan, J. H., & Schumacher, S. (2010). Research in education: Evidence-based inquiry. London: Pearson Higher Ed.

McMullin, E. (1984). A case for scientific realism. In J. Ladyman,. (1998). What is structural realism? Studies in History and Philosophy of Science Part A, 29(3), 409-424.

Merriam, S., Caffarella, R., & Baumgartner, L. (2007). Learning in adulthood. 3rd ed. San. Francisco: Jossey-Bass.

Meyer, B. J., & Meij, H. S. (1996). Fisiologie van die mens. Pinetown: Kohler Carton and Print.

Meyers, M. (2011). Exploring psychology. (8th ed.). Gordonsville, VA: Worth Publishers.

Miller, D. (1987). Material culture and mass consumption. Oxford: Basil Blackwell.

Miller, G. (1997). Becoming miracle workers: Language and meaning in brief therapy. Hawthorne NY: Aldine de Gruyter.

Miller, G., & Foster, T. F. (2010). Critical synthesis of wellness literature. University of Victoria Faculty of Human and Social Development & Department of Geology.

Miller, J. M. (2005). Wellness: The History and Development of a Concept. Spektrum Freizeit, 1.

Miller, K., & Massie, M. J. (2006). Depression and anxiety. The Cancer Journal, 12(5).

Moerman, D. E. & Jonas, W. B., (2002). Deconstructing the placebo effect and finding the meaning response. Annals of Internal Medicine, 136(6), 471–476.

Mol, A. (2009). Living with diabetes: Care beyond choice and control. Lancet, 373(9677), 1756-1757.

Moore, T. & Thomas, P. (1994), Care of the soul. New York: Recorded Books.

Morris, J., & Sherwood, S. (1975). A retesting and modification of the PGC morale scale. Journal of Gerontolology, 30(1), 77-84.

Mossey, J., & Shapiro, E. (1982). Self-rated health: A predictor of mortality among the elderly. American Journal of Public Health, 72(8), 800-08.

Mroczek, D. K., & Kolarz, C. M. (1998). The effect of age on positive and negative affect: a developmental perspective on happiness. Journal of Personality and Social Psychology, 75(5), 1333.

Myers, J. E. & Sweeney, T. J. (2004). The indivisible self: An evidence-based model of wellness. Journal of Individual Psychology, 60, 234-244.

Myers, J. E. & Sweeney, T. J. (2008). Wellness counseling: The evidence base for practice. Journal of Counseling and Development, JCD, 86(4), 482.

Myers, J. E. (1992). Wellness, prevention, development: The cornerstone of the profession. Journal of Counseling and Development, 71 (2), 136-139.

Myers, J. E. (1998). The wellness evaluation of lifestyle manual. Palo Alto, CA: Mindgarden.

Myers, J. E., & Bechtel, A. (2004). Stress, wellness, and mattering among cadets at West Point: Factors affecting a fit and Healthy force. Military Medicine, 169(6), 475-483.

Myers, J. E., & Degges-White, S. (2007). Aging well in an upscale retirement community: The relationships among perceived stress, mattering, and wellness. Adultspan: Theory Research & Practice, 6(2), 96-110.

Myers, J. E., & Mobley, A. K., (2004). Wellness of undergraduates: Comparisons of traditional and nontraditional students. Journal of College Counseling, 7(1), 40–49. Retrieved from: 10.1002/j.21611882.2004.tb00258.x\nhttp://offcampus.lib.washington.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=2004-13710-007&site=ehost-live\njemyers@uncg.edu.

Myers, J. E., & Sweeney, T. J (2005). The five factor wellness inventory. Palo Alto, CA: Mindgarden.

Myers, J. E., & Sweeney, T. J. (2004). The indivisible self: An evidence-based model of wellness. Journal of Individual Psychology.

Myers, J. E., & Sweeney, T. J. (2008). Wellness counseling: The evidence base for practice. Journal of Counseling & Development, 86, 482-493.

Myers, J. E., & Sweeney, T. J. (Eds.). (2005). Wellness in counseling: Theory, research, and practice. Alexandria, VA: American Counseling Association.

Myers, J. E., & Williard, K. (2003). Integrating spirituality into counselor preparation: A developmental, approach. Counseling and Values, 47(2), 142–155. Retrieved from: http://proquest.umi.com/pqdlink?did=290444051&sid=1&Fmt=3&clientId=63890&RQT=309&VName=PQD.

Myers, J. E., & Sweeney, T. J. (2005). The indivisible self: An evidence-based model of wellness. Journal of Individual Psychology, 61(3), 269-279.

Myers, J. E., Luecht, R. M., & Sweeney, T. J. (2004). The factor structure of wellness: Reexamining theoretical and empirical models underlying the wellness evaluation of lifestyle (WEL) and the five-factor WEL. Measurement and Evaluation in Counseling & Development, 26(Jan).

Myers, J. E., Sweeney, T. J., & Witmer, J. M. (1998). The wellness evaluation of lifestyle. Greensboro, NC: Authors.

Myers, J. E., Sweeney, T. J., & Witmer, J. M. (2000). The wheel of wellness counseling for wellness: A holistic model for treatment planning. Journal of Counseling & Development, 78(3), 251–266. Retrieved from: http://doi.wiley.com/10.1002/j.1556-6676.2000.tb01906.x.

Myers, J. E., Sweeney, T. J., & Witmer, M. (2000). Counseling for wellness: A holistic model for treatment planning. Journal of Counseling and Development, 78(3), 251-266.

Myers, J. E., Witmer, J. M., & Sweeney, T. J. (2001). Wellness evaluation of lifestyle: Workbook. Menlo Park, CA: Mind Garden.

Myers, J., & Sweeney, T. (2004). The indivisible self: An evidence-based model of wellness. Journal of Individual Psychology, 60(3), 234–245. Retrieved from: http://libres.uncg.edu/ir/uncg/f/j_myers_indivisible_2004.pdf.

Myss, C. (1999). Anatomy of the spirit. London: Bantam Books.

National Center for Complementary and Alternative Medicine. (n.d.). Energy Medicine: An Overview. [Online] Retrieved from: http://www.healthy.net/Health/Article/Energy_Medicine_An_Overview/2407.

National Wellness Institute (NWI). (n.d.). The Six Dimensions of Wellness Model. Retrieved from: http://www.nationalwellness.org.

Neugarten, B., Havighurst, R., & Tobin, S. (1961). The measurement of life satisfaction. Journal of Gerontology, 16, 134-43.

Nevid, J. S., Rathus, S. A., & Greene, B. (2011). Abnormal psychology in a changing world. (8th ed.) Boston: Pearson.

Nicholas, D., Gobble, D., Crose, R., & Frank B. (1992). A systems view of health, wellness and gender: Implications for mental health counseling. J Mental Health Couns, 14(1), 8-19.

Nichter, M., & Nichter, M. (1991): Hype and weight. Medical Anthropology, 13, 249-84.

Norcross, J. C., & Goldfried, M. R. (2005). Handbook of psychotherapy integration. London: Oxford University Press.

O'Connor, J., & Seymour, J. (1995). Introducing NLP: Psychological skills for understanding and influencing people. London: Thorsons.

O'Connor, J. (2003). Manual de programação neurolinguística. Rio de Janeiro: Editorial Quality Mark.

O'Toole, G. (2012). Quote investigator. Retrieved from: http://quoteinvestigator.com/2011/12/16/spirit-manifest/.

Oliver, K. W., & Bao, L. (2002). Student resources in quantum mechanics, or why students need meta-resources. arXiv preprint physics/0207090.

Olivo, E. (2006). Energy Medicine. [Online]. Retrieved from: http://www.oprah.com/health/Energy-Medicine/4.

Oshman, J. R. (2000) Energy medicine: The scientific basis. Edinburgh: Churchill Livingstone.

Palombi, B. J. (1992). Psychometric properties of wellness instruments. Journal of Counseling and Development, 71(2), 221.

Parke, H., & Wormell, D. (1956). The Delphic Oracle. London: Basil Blackwell.

Parsons, R. (2006). Wellness factors in first year college students. American Journal of Health Studies, June issue.

Passon, O. (2006). What you always wanted to know about Bohmian mechanics but were afraid to ask. arXiv preprint quant-ph/0611032. Invited talk at the spring meeting of the Deutshe Phusikalische Gselschaft, Dorlmund. Forthcoming in Physics and Philosophy.

Patel, V., Kim, Y. R. (2002-2004). Contribution of low- and middle-income countries to research published in leading general psychiatry journals. Br J Psychiatry, 190, 77-8. PMID:17197661 doi:10.1192/bjp.bp.106.025692

Patel, V., & Sumathipala, A. (2001). International representation in psychiatric journals: A survey of 6 leading journals. Br J Psychiatry, 178, 406-9. PMID:11331553 doi:10.1192/bjp.178.5.406.

Paul, M. (2011). What does it mean to be a spiritual person? [Online] Retrieved from: http://www.nursetogether.com/Lifestyle/Lifestyle-Article/itemId/1264/What-Does-it-Mean-to-be-a-Spiritual-Person-.aspx.

Peng, C. Y., Graves, P. R., Ogg, S., Thoma, R. S., Byrnes, M. J., 3rd, Wu, Z., … & Piwnica-Worms, H. (1998). C-TAK1 protein kinase phosphorylates human Cdc25C on serine 216 and promotes 14-3-3 protein binding. Cell growth & differentiation. The Molecular Biology Journal of The American Association for Cancer Research, 9(3), 197-208.

Perls, F. S. (1969). Ego, hunger and aggression: The beginning of Gestalt therapy, 273. New York: Crown Publishing Group.

Pert, C. (1997). Molecules of emotion. USA: Simon & Schuster.

Pert, C. B. (2003). Molecules of emotion. New York: Scribner.

Pert, C. B. (2006). Everything you need to know about how to feel go(o)d. Carlsbad: Hay House.

Peterson, C. (2009). Positive Psychology. Reclaiming Children and Youth, 18(2), 3-7.

Pignotti, M. (2005). Thought field therapy voice technology vs. random meridian point sequences: A single-blind controlled experiment. The Scientific Review of Mental Health Practice, 4(1), 72-81.

Pilch, J. (1998). Wellness spirituality. Retrieved from: http://www.georgetown.edu/faculty/pilchj/wellart.htm.

Pourdehnad, J., Wexler, E. R., & Wilson, D. V. (2011). Systems & design thinking: a conceptual framework for their integration. Organizational Dynamics Working Papers, Working Paper #11-03 and Proceedings of the 55th Annual Meeting of the International Society for the Systems Sciences.

Powers, A. S., Myers, J. E., Tingle, L. R., & Powers, J. C. (2004). Wellness, perceived stress, mattering, and marital satisfaction among medical residents and their spouses: Implications for education and counseling. Family Journal, 12(1), 26.

Pratt, L. A., & Brody, D. J. (2008). Depression in the United States household population. Age, 18, 39.

Presley, C. A., Meilman, P. W., & Lyerla, R. (1994). Development of the Core Alcohol and Drug Survey: Initial findings and future directions. Journal of American College Health, 42(6), 248-255.

Prochaska, J. O., & DiClemente, C. C. (1982). Trans-theoretical therapy: Toward a more integrative model of change. Psychotherapy: Theory, Research and Practice 19(3), 276-288.

Prochaska, J. O., & DiClemente, C. C. (1992). Stages of change in the modification of problem behaviors. Progress in Behavior Modification, 28.

Prochaska, J. O., DiClemente, C. C. (2005). The transtheoretical approach. In J. C. Norcross, & M. R. Goldfried (Eds.) Handbook of psychotherapy integration. (2nd ed.). New York: Oxford University Press,147–171.

Procidano, M. (1992). The nature of perceived social support: Findings of meta-analytic studies. In: Spielberger & Butcher (Eds). Advances in Personality Assessment, 9, 1-26.

Procidano, M. E., & Heller K. (1983). Measures of perceived support from friends and from family: Three validation studies. Am J Comm Psychol, 11(1), 1-24.

Quimby, P. (1864). Curing without medicine. Retrieved from: http://ppquimby.com/articles/curing_without_medicine.htm.

Radin, D. (2008). Testing nonlocal observation as a source of intuitive knowledge. Explore: The Journal of Science and Healing, 4(1), 25–35.

Ragheb, M. G. (1993). Leisure and perceived wellness: A field investigation. Leisure Sciences, 15, 13–24.

Rankin, L. (2013). Mind over medicine. New York: Hay House.

Rasmussen, H. N., Scheier, M. F., & Greenhouse, J. B. (2009). Optimism and physical health: A meta-analytic review. Annals of Behavioral Medicine, 37(3), 239-256.

Rathus, S. A. (1984). Psychology. New York: CBS College Publishing.

Reed, D., McGee, D., Yano, K., & Feinleib, M. (1983). Social networks and coronary heart disease among Japanese men in Hawaii. Am J Epidemiol, 117(4), 384-96.

Reker, G., & Peacock, E. (1981). The life attitude profile (LAP): A multidimensional scale for assessing attitudes toward life. Can J Behav Sci, 13(3), 264-73.

Reker, G., & Wong, P. (1984). Psychological and physical well-being in the elderly: The perceived well-being scale. J Aging, 3(1), 23-32.

Reker, G., Peacock, E., & Wong, P. (1987). Meaning and purpose in life and well-being: A life-span perspective. J Gerontol, 42(1), 44-49.

Roach, L. F. & Young, M. E. (2007). Do counselor education programs promote wellness in their students? Counselor Education and Supervision, 47(1), 29-45.

Robertson, D. (2010). The philosophy of cognitive-behavioural therapy: Stoicism as rational and cognitive psychotherapy. London: Karnac.

Robertson, D. (2010). The philosophy of cognitive-behavioural therapy: Stoicism as rational and cognitive psychotherapy. London: Karnac.

Robinson, K. S. (2009). Galileo's dream. USA: Ballantine Books.

Rodin, J., & Langer, E. (1977). Long-term effects of a control-relevant intervention with the institutionalized aged. J Pers Soc Psychol, 35(12), 897-902.

Rosenbaum, M. E. (1990). Learned resourcefulness: On coping skills, self-control, and adaptive behavior. New York: Springer.

Rosenfield, S. (1997). Labeling mental illness: The effects of received services and perceived stigma on life satisfaction. American Sociological Review, 660-672.

Ross, J. S. (2002). Work, power, kinetic energy. Project PHYSNET. Michigan State University. Retrived From: http://www.physnet.org/modules/pdf_modules/m20.pdf.

Rothmann, S., & Ekkerd, J. (2007). The validation of the perceived wellness survey in the South African police service. SA Journal of Industrial Psychology, 33(3), 35-42.

Rotter, J. B. (1966). Generalized expectancies for internal versus external control of reinforcement. Psychological Monographs: General and Applied, 80(1), 1.

Rowe, G., & Wright, G. (1999). The Delphi technique as a forecasting tool: Issues and analysis. International Journal of Forecasting, 15(4), 353-375.

Russell, & Hanson, N. (1959). It's actual, so it's possible. Philosophical Studies, 10(5), 69-80.

Russell, B. (2004) (First published in 1947). History of western philosophy. New York: Simon & Schuster.

Ryan, R. M. & Deci, E. L. (2001). On happiness and human potentials: A review of research on hedonic and eudaimonic well-being. Annual Review of Psychology, 52(1), 141-166.

Ryff, C. (1989). Happiness is everything, or is it? Exploration on the meaning of psychological well-being. Journal of Personality and Social Psychology, 57(6), 1069-81.

Ryff, C. D., & Keyes, C. L. M. (1995). The structure of psychological well-being revisited. Journal of Personality and Social Psychology, 69(4), 719.

Sakai, C., Paperny, D., Mathews, M., Tanida, G., Boyd, G., Simons, A., … Nutter, L. (200). Thought Field Therapy clinical applications: Utilization in an HMO in behavioral

medicine and behavioral health services. Journal of Clinical Psychology, 7(10), 1215-1227.

Sarvimäki, A. (2006). Well-being as being well: A Heideggerian look at well-being. International Journal of Qualitative Studies on Health and Well-being, 1(1), 4-10.

Scheier, M., & Carver, C. (1985). Optimism, coping and health: Assessment and implications of generalized outcome expectancies. Health Psychology, 4(3), 219-47.

Scheier, M., Matthews, K., Owens, J., Magovern, G., Lefebvre, R., Abbott, R., & Carver, C. (1989). Dispositional optimism and recovery from coronary artery bypass surgery: The beneficial effects on physical and psychological well-being. Journal of Personality and Social Psychology, 57, 1024-40.

Schnurr, P. P., Fiore, L. D. & Watts, B. V. (2013). Measuring use of evidence based psychotherapy for posttraumatic stress disorder. Administration and Policy in Mental Health and Mental Health Services Research, 40(4), 311-318.

Schwartz, B. (2000). Self-determination: The tyranny of freedom. American Psychologist, 55(1) 79–88.

Schwartz, R. (2012). Enhancing therapy with energy psychology. The National Psychologist, Jan/Feb.

Scotton, B., Chinen, A., & Battista, J. (Eds). (1996). The textbook of transpersonal psychiatry and psychology. USA: Basic Books.

Seeley, J., & van der Gulik, A. (2009). Get unstuck for kids: The workbook. California: Blue Moon Wonders.

Seeman, J. (1989). Toward a model of positive health. Am Psychol, 44(8), 1099-1109.

Seeman, T., & Syme, S. (1987). Social networks and coronary artery disease: A comparison of the structure and function of social relations as predictors of disease. Psychosom Med, 49, 341-54.

Seley, H. (1980). The stress concept. In: L. L. Kutash, L. B. Schlesinger & Associates, Handbook on stress and anxiety, 135, 11-19.

Seligman, M. E. (1975). Helplessness: On depression, development, and death. New York: WH Freeman/Times Books/Henry Holt & Co.

Seligman, M. E. (1996). Science as an ally of practice. American Psychologist, 51(10), 1072.

Seligman, M. E. (2000). Special issue on happiness, excellence, and optimal human functioning. New York: American Psychological Association.

Seligman, M. E. (2002). Positive psychology, positive prevention, and positive therapy. Handbook of Positive Psychology, 2, 3-12.

Seligman, M. E. (2004). Authentic happiness: Using the new positive psychology to realize your potential for lasting fulfillment. New York: Simon and Schuster.

Seligman, M. E. (2011). Learned optimism: How to change your mind and your life. New York: Vintage.

Seligman, M. E. P. (2002). Authentic happiness: Using the new positive psychology to realize your potential for lasting fulfillment. New York: Free Press.

Seligman, M. E. P., & Csikszentmihalyi, M. (2000). Positive psychology. An Introduction. American Psychologist, 55(1), 5–14.

Seligman, M. E. P., Parks, A. C., & Steen, T. (2005). A balanced psychology and a full life. In F. A. Huppert, N. Baylis, B. Keverne (Eds.), The science of well-being. Oxford: Oxford University Press.

Selye, H. (1955). Stress and disease. Science, 122(Oct.), 625-631.

Selye, H. (1974). Stress without distress. New York: LP Lippincott.

Selye, H. (1986). Stress, cancer, and the mind in Cancer, stress, and death. New York: Springer, 1-19.

Sharp, W. R. (1947). The new world health organization. Am. J. Int'l L., 41, 509.

Sheldon, B. (2011). Cognitive-behavioural therapy: Research and practice in health and social care. Routledge. London.

Sheldon, K., Frederickson, B., Rathunde, K., Csikszentmihalyi, M., & Haidt, J. (2000). Positive Psychology Manifesto. Retrieved from: http://www.ppc.sas.upenn.edu/akumalmanifesto.htm.

Sheldrake, R. (2011). The presence of the past: Morphic resonance and the habits of nature. Icon Books.

Sherer, M., Maddux, J. E., Mercandante, B., Prentice-Dunn, S., Jacobs, B., & Rogers, R. W. (1982). The self-efficacy scale: Construction and validation. Psychological Reports, 51(2), 663-671.

Shiner, B., D'Avolio, L. W., Nguyen, T. M., Zayed, M. H., Young-Xu, Y., Desai, R. A., ... & Watts, B. V. (2013). Measuring use of evidence based psychotherapy for posttraumatic stress disorder. Administration and Policy in Mental Health and Mental Health Services Research, 40(4), 311-318.

Sidman, C. L., D'Abundo, M. L., & Hritz, N. (2009). Exercise, self-efficacy and perceived wellness among college students in a basic studies course. International Electronic Journal of Health Education, 12, 162-174.

Siegfried, T. New analysis rescues quantum wave-particle duality. Retrieved from: http.//www.sciencenews.org/blog/context/new-analysis-rescues-quantum-wave-particle-duality.

Simos, G. (2002). Cognitive behaviour therapy: A guide for the practicing clinician (Vol. 1). Psychology Press.

Sinclair, L. S. & Meyers, J. E. (2004). The relationship between objectified body concoiusness and wellness in a group of college women. Journal of College Counselling, 7(Fall), 150-161.

Singer, E., Garfinkel, R., Cohen, S., & Srole, L. (1976). Mortality and mental health: Evidence from Midtown Manhattan restudy. Soc Sci Med, 10, 517-25.

Skinner, B. F. (1981). Selection by consequences. Science, 213(4507).

Smil, Vaclav (2008). Energy in nature and society: General energetics of complex systems. London: Cambridge.

Smith, C. (1998). The science of energy: A cultural history of energy physics in Victorian Britain. New York: The University of Chicago Press.

Snyder, C. R., Lopez, S. J., & Pedrotti, J. T. (2010). Positive psychology: The scientific and practical explorations of human strengths. New York: Sage.

Sorkin, D., Rook, K. S., & Lu, J. L. (2002). Loneliness, lack of emotional support, lack of companionship, and the likelihood of having a heart condition in an elderly sample. Annals of Behavioral Medicine, 24(4), 290-298.

Spiegel, A. (2006). More and more, favored psychotherapy lets bygones be bygones. The Cognitive Behavioral Institute of Albuquerque. [Online] Retrieved from: http://www.cogtherapy.com/about%20cbt.htm.

Spiegel, A. (2006). Unorthodox therapy in New Orleans raises concern. National Public Radio. [Online] Retrieved from: http://www.npr.org/templates/story/story.php?storyId=5309328.

Spielberger, C. D., Denike, L. D. (1966). Descriptive behaviorism versus cognitive theory in verbal operant conditioning. Psychological Review, 73(4).

Spitzer, R. (1992) Virginia Satir & origins of NLP. Anchor Point, July issue.

Stanford, R. G. (1990). An experimentally testable model for spontaneous psi events. In S. Krippner (Ed.), Advances in parapsychological research, vol. 6 (pp. 54-167). Jefferson, NC: McFarland.

Stats, S. (1996). Population census 1996. Community profile databases, version 3.

Steptoe, A. & Kivimäki, M. (2012). Stress and cardiovascular disease. Nature Reviews Cardiology, 9(6), 360-370.

Stevens, F., & ten-Have, M. (1993). Activity level, boredom, health and participative climate in nursing homes. Tijdschr Gerontol Geriatr, 24(1), 18-23.

Stewart, A., Hays, R., & Ware, J. (1992). Health perceptions, energy/fatigue, and health distress measures. Measuring functioning and well-being: The medical outcomes study approach. Durham, North Carolina: Duke University.

Stewart, W. F., Ricci, J. A., Chee, E., Hahn, S. R., & Morganstein, D. (2003). Cost of lost productive work time among US workers with depression. Jama, 289(23), 3135-3144.

Stewart-Williams, S., & Podd, J. (2004). The placebo effect: Dissolving the expectancy versus conditioning debate. Psychological Bulletin, 130(2), 324–340.

Stone, B., Leyden, L., & Fellows, B. (2009). Energy psychology treatment for posttraumatic stress in genocide survivors in a Rwanda orphanage: A pilot investigation. Energy Psychology: Theory, Research and Treatment, 1(1).

Stravynski, A., & Boyer, R. (2001). Loneliness in relation to suicide ideation and parasuicide: A population-wide study. Suicide and Life-Threatening Behavior, 31(1), 32-40.

Strohecker, J. (Executive Ed.) (1994). Alternative medicine: The definitive guide. Compiled by the Burton Goldberg Group. Puyallup, WA: Future Medicine Publishing.

Strümpfer, D. (1995). The origins of health and strength: From 'salutogenesis' to 'fortigenesis'. South African Journal of Psychology, 25(2), 81-89.

Sumber, J. (2011). Services. [Online] Retrieved from: http://www.jeffreysumber.com/services/.

Sweeney, T. J. (1998b) Adlerian theory. In D. Cappuzzi & D. R. Gross (Eds.), Counseling and psychotherapy (pp. 113–150). Englewood Cliffs, NJ: Prentice Hall.

Sweeney, T. J., & Myers, J. E. (2003). The indivisible self: An evidence-based model of wellness. Greensboro, NC: Authors.

Sweeney, T. J., & Myers, J. E. (2005). Optimizing human development: A new paradigm for helping. In A. Ivey, M. B. Ivey, J. E. Myers, & T. J. Sweeney (Eds.), Developmental counseling and therapy: Promoting wellness over the lifespan (pp. 39–68). New York: Houghton-Mifflin/Lahaska.

Sweeney, T. J., & Witmer, J. M. (1991). Beyond social interest: Striving toward optimal health and wellness. Individual Psychology, 47, 527–540.

Szasz, T. (1974). The myth of mental illness: foundations of a theory of personal conduct, revised edition. Perennial, New York.

Talbot, M. (2011). The holographic universe. New York & London: Harper Perennial.

Tatar, M., & Myers, J. E. (2010). Wellness of children in Israel and the United States: A preliminary examination of culture and well-being. Counseling Psychology Quarterly, 1, 17-33. doi: 10.1080/09515071003718384

Taylor, C. & Robinson, C. (2009). Student voice: Theorising power and participation. Pedagogy, Culture & Society, 17(2), 161-175.

Taylor, S. E. (1995). Situational determinants of placebo effects in health psychology (7th ed.). New York: McGraw-Hill.

Taylor, S., & Brown, J. (1988). Illusion and well-being: A social psychological perspective on mental health. Psychol Bull, 103(2), 193-210.

Terre Blanche, M., Kelly, K., Durrheim, K., & Painter, D. (2006). Why qualitative research. Research in Practice: Applied Methods for the Social Sciences, 2, 271-284.

Strohecker, J. (Exec. Ed.). (1994). Alterative medicine. The definitive guide. Washington: Future Medicine Publishing.

The Da Vinci Institute. (2012). Managing the systems way. [Lecture notes] for PhD MOTI, Leonardo Programme.

The South African College of Applied Psychology (SACAP). 2011. Bachelor of Psychology (Counselling) Degree. [Online]. Retrieved from: http://www.sacap.edu.za/qualifications/bpsych-degree/. Accessed 17.12.2011.

Thoms, P., Moore, K. S., & Scott, K. S. (1996). The relationship between self-efficacy for participating in self-managed work groups and the big five personality dimensions. Journal of Organizational Behavior, 17(4), 349-362.

Tomei, L. (2004) Educational Psychology. [Online] Retrieved from: http://academics.rmu.edu/~tomei/ed711psy/c_info.htm

Tomlinson, M., Rudan, I., Saxena, S., Swartz, L, Tsai, A. C., & Patel, V. (2009). Setting priorities for global mental health research. World Health Organisation Bulletin, 87, 438–446.

Travis, J. (1975). Wellness inventory. Mill Valley, CA: Wellness Publications.

Travis, J. (1977). Wellness workbook for healthpProfessionals. Mill Valley, CA: Wellness Publications.

Travis, J., & Ryan, R. (1981, 1988, 2004). Wellness workbook. Berkeley, CA: Ten Speed Press.

Travis, J., & Ryan, R. (1988). Wellness workbook (2nd ed.) Berkeley, CA: Ten Speed Press.

Travis, J. W. (1981). The wellness inventory. Mill Valley, CA: Wellness Associates.

Trubo, R., & Callahan, R. (2001). Tapping the healer within: Using thought field therapy to instantly conquer your fears, anxieties, and emotional distress. Chicago, Ill: Contemporary Books.

Tsai, C. (2004). The relationships between leisure participation and perceived wellness among Taiwanese adults ages 55 to 75 years (China). Dissertation at University of the Incarnate Word.

Tummers, L., & Karsten, N. (2012). Reflecting on the role of literature in qualitative public administration research: Learning from grounded theory. Administration & Society, 44, 64–86.

Tuohimaa, H. (2-13). Responsibility for health and wellbeing: Looking forward. Retrievd from: http://www.inter-disciplinary.net/probing-the-boundaries/wp-content/uploads/2013/04/hannarlpaper.

UNISA. (2011). BEGESOA Tutorial Letter, 201/0/2011. Pretoria: UNISA.

Vaillant, G. E. (2012). Triumphs of experience. London: Harvard University Press.

Van Rensburg, P. (1987). Kognitiewe gedragsterapie en vitamien B6 as behandelisgsmetodes vir depressie. (Unpublished thesis, MA (Psychology)). University of Pretoria, Pretoria, South Africa.

Van Rensburg, P. (1999a). Access health: Mental health management programme. Unpublished research document – available from author.

Van Rensburg, P. (1999b). Relax about anxiety. Available from author.

Van Rensburg, P. (1999c). Uplifting thoughts about depression. Available from author.

Van Rensburg, P. M. (2012). Solving a wicked problem in a medical practice using managing the systems way thinking. (Unpublished paper submitted to the Da Vinci Institute). Available from author.

Vas, S. (2009) Theory and practice of cognitive behavioral therapy. [Online] Retrieved from: www.psychclerk.bsd.uchicago.edu/cbt.ppt.

Veenhoven, R. (1991). Is happiness relative? Social Indicators Research, 24(1), 1-34.

Veenhoven, R. (1994). Is happiness a trait? Social Indicators Research, 32(2), 101-160.

Veenhoven, R. (2005). World database of happiness, distributional findings in nations. Rotterdam: Erasmus University.

Vella-Brodrick, D., & Page, K. (2011). Positive leadership: Accentuating and cultivating human resources. [Online]. Retrieved from: http://hdl.handle.net/11343/49605

Wagner-Moore, L. E. (2004). Gestalt therapy: Past, present, theory, and research. Psychotherapy: Theory, Research, Practice, Training, 41(2), 180.

Walach, H., & Römer, H., 2000. Complementarity is a useful concept for consciousness studies. A reminder. Neuroendocrinology Letters, 21(3), 221–232.

Walker, S., Sechrist, K., & Pender, N. (1987). The health-promoting lifestyle profile: Development and psychometric characteristics. Nurs Res, 36(2), 76-81.

Ware, J., & Sherbourne, C. (1992). The MOS 36-item Short-form Health Survey (SF-36). Medical Care, 30(6), 473-483.

Warner, K. E. (1987). Selling health promotion to corporate America: Uses and abuses of the economic argument. Health Education Quarterly, 14(1), 37-55.

Wasserman, J. A., Clair, J. M., & Wilson, K. L. (2009). Problematics of grounded theory: Innovations for developing an increasingly rigorous qualitative method. Qualitative Research, 9, 355–381.

Well People. (n.d.). A new vision of wellness. Retrieved from: http://www.wellpeople.com.

Wendt, A. (2004). Social theory as Cartesian science: An auto-critique from a quantum perspective. ?

Wethington, E., & Kessler, R. (1986). Perceived support, received support, and adjustment to stressful life events. J Health Soc Behav, 27, 78-89.

Whalen, K. (2015). Pharmacology. Alphen aan den Rijn, Netherlands: Wolters Kluwer.

Whitfield, G., & Davidson, A. (2007). Cognitive behavioural therapy explained. Radcliffe Publishing.

Whitmer, J., & Sweeney, T. (1992). A holistic model for wellness prevention over the life span. J Couns Dev, 71, 140-48.

Williams, P., Wiebe, D., & Smith, T. (1992). Coping processes as mediators of the relationship between hardiness and health. J Behav Med, 15(3), 237-55.

Williams, S. J. (2000). Reason, emotion and embodiment: Is 'mental' health a contradiction in terms? Sociology of Health & Illness, 22(5), 559–581.

Wilson, I., & Cleary, P. (1995). Linking clinical variables with health-related quality of life. JAMA, 273(1), 59-65.

Wissing, M. P., & van Eeden, C. (1997). Psychological well-being: A fortigenic conceptualisation and empirical clarification. Paper presented at Annual Congress of the Psychological Society of South Africa, Durban, South Africa.

Wissing, M. P., & van Eeden, C. (2002). Empirical clarification of the nature of psychological well-being. South African Journal of Psychology, 32, 32-44.

Witmer, J. M., & Sweeney, T. J. (1992). A holistic model for wellness and prevention over the life span. Journal of Counseling & Development, 71, 140–148.

Witmer, J. M., & Sweeney, T. J. (1998). Toward wellness: The goal of counseling. In T. J. Sweeney, Adlerian counseling: A practitioner's approach (pp. 43–99). Philadelphia: Accelerated Development, Taylor & Francis.

Witmer, J. M., Sweeney, T. J., & Myers, J. E. (1998). The wheel of wellness. Greensboro, NC: Authors.

Wolberg, L. R. (1977). The technique of psychotherapy. New York: Grune & Stratton.

Wood, V., Wylie, M., & Sheafor, B. (1969). An analysis of a short self-report measure of life satisfaction: Correlation with rater judgments. J Gerontol, 24(4), 465-69.

World Health Organization (WHO). (1947). Constitution. Available at http://policy.who.int/cgi-bin/om_isapi.dll?hitsperheading=on&infobase=basicdoc&jump=Constitution&softpage=Document42#JUMPDEST_Constitution.

World Health Organization (WHO). (1964). Basic documents (15th ed.). Geneva, Switzerland.

World Health Organisation (WHO). (2011). WHO's Executive Board adopted draft resolution on mental health EB130.R8. Retrieved from: http://www.who.int/mental_health/en/.

World Health Organisation (WHO). (2011). Mental Health. [Online] Retrieved from: at www.who.int.

Wright, J. H. (Ed.). (2004). Cognitive-behavior therapy. Review of Psychiatry, 23(3).

Wu, R. (1986). Behavior and illness (pp. 77-85). New Jersey: Prentice-Hall.

Yin, R. (2009). How to do better case studies. The SAGE handbook of applied social research methods, 2, 254-282.

Young, J., and J. Klosko. 1993. Reinventing Your Life: How to Break Free from Negative Life Patterns. New York: Dutton.

Appendix

QSDA QUESTIONNAIRE

I. AFFECTIVE

How do you feel most of the time?

Which of the following describes your feelings the best:

Sad, tense, angry, down or panicky?

Which of these are the most prominent?

⊙DEPRESSED MOOD (Down/blue/sad/gloomy)

⊙LOSS OF PLEASURE (Previously enjoyed tasks)

⊙GUILT FEELINGS

⊙ANXIETY (Tense/Stressed/Highly strung)

⊙ANGER/IRRiTaBILITY

PANICKY / FEAR (for 10 – 20 mins)

⊙Feeling ON EDGE / RESTLESS

⊙FEARED SITUATIONS (Social, spaces, animals, injections, blood)

II. COGNITIVE

What bothers you about your thoughts or thinking abilities?

Do you have thoughts which scare or shock you?

⊙Mentions LIFE THREATENING

EXPERIENCE

⊙CONCENTRATION (Attention/short-term

memory)

⊙INDECISIVENESS (Reasoning)

⊙Excessive WORRYING (<u>not</u> about panic attack)

⊙<u>SUICIDE (thoughts, wishes, plans)</u>

Thoughts: HEART ATTACK/GOING MAD/DYING

⊙<u>FLASHBACKS</u>: (Traumatic event/reliving

traumatic event)

⊙Avoid thoughts with TRAUMATIC EVENT

⊙DREAMS of TRAUMATIC EVENT

OBSESSIONS: intrusive, persistent thoughts,

Impulses or images

⊙Mind going BLANK

WORRYING about another PANIC ATTACK

III. MOTIVATIONAL

How motivated or interested are you to do the things you used to do or enjoy. E.g., hobbies, chores, your work?

Are you purposefully avoiding certain situations?

⊙Lack of INTEREST/MOTIVATION

⊙AVOIDANCE BEHAVIOUR (elevators, flying,
Injections, animals, etc

IV. BEHAVIOUR

Which behaviour do you display that bothers you?

Which of your behaviour interferes with your everyday functioning?

⊙LOSS OF ENERGY (tired, fatigue, drained)

⊙SOCIAL WITHDRAWAL

⊙CRYING (more than usual)

COMPULSIONS (repetitive behaviour – hand
washing, checking – or mental activities –
counting or praying)

⊙TRIGGERS IN ENVIRONMENT (sounds, smells)
which cause flashbacks

⊙SLOW SPEECH / SLOW MOVEMENTS

⊙HYPER-ALERT

⊙STARTLE RESPONSE

V. SOMATIC

What happens to your body when you feel tense of panicky?

Palpitations
Sweating
Dizziness: feel like fainting/unsteady/light-
Headed
Trembling or shaking
Chest pain or discomfort
Nausea or abdominal distress
Sensations of shortness of breath or suffo-
cating
Feeling of choking
Muscular tension
Numbness or tingling sensations
Chills or hot flushes

⊙Feelings of unreality or feeling detached/dis-
tanced from self and others

⊙SLEEPLESSNESS or SLEEPING TOO MUCH

⊙Restless disturbed SLEEP

⊙Loss or increase of APPETITE and/or loss of
WEIGHT

VI. FREQUENCY / DURATION

How often …? How long …?

DEPRESSION: ⊙2 or more weeks ⊙2 or more years

PHOBIA/GENERALISED ANXIETY: ⊙6 or more months

POST TRAUMATIC STRESS: ⊙one or more months

:

DIAGNOSIS

For example:

(i) Affective: *How do you feel most of the time?*

Which of the following describes your feelings the best?

The member might answer as follows:

Member A	Member B
- Depressed mood	- Feeling on edge
- Loss of pleasure	
- Guilt feelings	

(ii) Cognitive: *"What bothers you about your thoughts or "thinking abilities?"*

"Do you have thoughts which scare or shock you?"

The member might answer as follows:

Member A	Member B
- Lack of concentration	- Excessive worrying
- Suicide thoughts	- Indecisiveness

(iii) Motivational: *"How motivated or interested are you to do the things you used to do or enjoy, e.g., hobbies, chores, your work? Are you purposefully avoiding certain situations?*

The member might answer as follows:

Member A	Member B
- Lack of interest/motivation	- None

(iv) Behaviour: *"Which behaviour do you display that bothers you?"*

"Which of your behaviour interferes with your everyday functioning?"

The member might answer as follows:

Member A	Member B
- Loss of energy	- Hyper alert
- Social withdrawal	- Social withdrawal
- Crying (more than usual)	

(v) Somatic: *"What happens to your body when you feel tense or panicky?"*

The member might answer:

Member A	Member B

- Restlessness
- Loss of appetite

- Muscular tension
- Trembling or shaking

Diagnosis:

Member A – Depression

Member B – Vague signs of anxiety

(vi) Frequency/Duration

"How often?/How long?"

Member A: 2 or more weeks (3 months)

Member B: one or more months (one and a half months)

The next step would be to access the degree of severity of mental problem (CSMP). The CSMP is based on the assumption the following factors are important:

Design

The CSMP is based on the assumption that in order to determine the degree of mental problems, the following factors need to be taking into account:

(i) Number of psychiatric disorders
(ii) Matters relating to suicide
(iii) Impairment in areas of life
(iv) Substance abuse
(v) Previous treatment
(vi) Support systems

The above outlined factors resemble to a great extent the Axis-V diagnosis as per DSM-IV. Nonetheless, the CSMP does differ from the DSM-IV - Axis-V diagnosis in several ways. Firstly, the CSMP does not access personality functioning. The reason is that such an evaluation is very time-consuming and is best conducted in an eye-to-eye situation and over a period of time.

Secondly, the CSMP provides specific ratings, as well as specific guidelines regarding rating.

Thirdly, the CSMP certain sub-factors have been pre-selected, for quick "diagnosis" and are geared towards identifying the most serious cases as quickly as possible.

Application

It takes approximately 5 to 20 minutes to administer the CSMP. The relevant questions to be asked by Help line personnel have been specified and are illustrated with some specific examples, each with their respective rating. The latter can also be utilised as guidelines whenever a member experiences problems which differ from the specified ones. The ratings are as follows: Zero, One, Two and Three.

The computer will calculate the score and provide an estimate of the degree of severity and suggestions regarding the indicated method of intervention. The options are:

Suicide Risk : Urgent referral to Mental Health Professional
High Risk : Convince member to consult Mental Health Professional
Moderate – Low Risk : Help line and Member Material.

CHECKLIST
SEVERITY OF MENTAL PROBLEM
(CSMP)

CRITERIA	Rating 0	1	2	3
A. NUMBER OF PSYCHIATRIC DISORDERS None = 0 One = 1 Two or more = 3	0	1		3
B. SUICIDE Thoughts/wishes = 3 Previous attempts = 3				3
C. IMPAIRMENT IN AREAS OF LIFE *Do you experience problems or dilemmas with any of the following: Interpersonal (self, social, and family), work, finances or physical health?*				
INTERPERSONAL e.g. Lack of confidence = 1		1		
e.g. Marriage = 2			2	
e.g. Death = 3				3
WORK e.g. Work load/Pressure = 2			2	
e.g. Possible/Pending Retrenchment = 3				3
e.g. No promotion possibilities = 2			2	
FINANCIAL e.g. Debt – can't pay = 3				3
HEALTH (Physical) Life Threatening, (e.g. AIDS, Cancer) = 3 Chronic (e.g. Yuppie flu, Diabetes) = 2			2	3
D. SUBSTANCE ABUSE *Do you have more than 2 drinks per evening, almost every day?*				3
E. PREVIOUS TREATMENT *During the last year have you been HOSPITALISED because of emotional problems?* NO = 0 YES = 3	0			3
During the last year have you consulted a PSYCHOLOGIST NO = 0 YES = 1	0	1		
And/or PSYCHIATRIST NO = 0 YES = 1	0	1		
During the last year have you taken any MEDICATION for emotional problems (including sleep medication)? NO = 0 YES = 1	0	1		
F. SUPPORT SYSTEMS *Do you have people with whom you can share your problems And who are sympathetic?* NO = 3 YES = 0	0			3

To take the previous two members through this questionnaire, we have to ask the following questions:

		Member A	Member B
A	Number of psychiatric disorders	1	1
B	Suicide	3	0
C	Impairment in areas of life		
	- interpersonal	3	1
	- work	2	2
	- financial	0	0
	- health	0	0
D	Substance abuse	0	3
E	Previous treatment		
	- hospitalisation	3	0
	- psychologist	1	0
	- psychiatrist	1	0
	- medication	1	1
F	Support system	0	0

According to this protocol, Member A's scores high on factor B. Whenever factor B is prominent, it is necessary to refer the member immediately to a psychologist or a psychiatrist.

Member B's scores indicate that there are problems in A + (C is 4 or less) + D + E which put this member in the low risk group. This member could be helped by applying counselling procedures and member material. Whenever brochures and tapes are sent to the member it is important to stress that the member should do ALL the experiments in the sequence in which they are presented in the brochures. Nonetheless, it would be more effective to give the member a homework assignment and to make follow-up arrangements, instead of leaving them to their own resources. The member should also be invited to phone immediately when he/she has any problems or questions regarding the brochure, tapes or homework.

Help line/Counselling personnel should also inform the member that in order to measure the effectiveness of the service, "Evaluation of Treatment – forms" (Progress Report) will be sent to the member. Likewise, members currently receiving

treatment from a Health Specialist will also be requested to complete a Progress Report. The same applies to the service provider.

Frequently Asked Questions

(i) *What are the causes of Anxiety and Depression?*

There is no single "cause". Instead, there is always a variety of contributing factors present which interact in a complex fashion, and the exact interaction of these will differ from person to person. The most important contributing factors would be:

- Environment
- Thinking (thoughts/beliefs)
- Role Models (family history, genetics)
- Chemical imbalance
- Coping mechanisms
- Physical conditions
- Substances.

As you can see, the possible explanations for Depression or Anxiety are numerous. Nonetheless, in most instances, the two factors which play a crucial role in the "production" and "maintenance" of your depression or anxiety are psychological and bio-chemical ones.

Psychological Factors

Psychological factors are the factors relating to your thinking patterns, belief system (the manner in which you interpret yourself, others, and the world around you), and the coping mechanisms (problem solving abilities) which you use when dealing with stressful (real or imagined) circumstances. Interestingly, whenever there are dilemmas regarding any of these, these could –

- Adversely affect the chemical balance in your brain;
- Lower the functioning of your immune system; and
- Cause you to experience undue anxiety and/or depression.

Much research has been done about the relationship between thoughts (beliefs), feelings, and behaviour. And it has been proven over and over again: *THE QUALITY OF OUR THOUGHTS TO A GREAT EXTENT INFLUENCE THE QUALITY OF OUR FEELINGS AND BEHAVIOUR.* This is an important and empowering piece of information, because it means that by applying new or different ways of thinking (e.g., beliefs and problem solving skills), we are able to create some of the feelings or behaviour we would like to experience!

Furthermore, by CHANGING OUR BEHAVIOUR WE CAN INFLUENCE OUR FEELINGS AND THOUGHTS.

Example of Anxiety. For example, instead of allowing ourselves to be ANXIOUS or AFRAID whenever approaching/riding in an elevator, we could teach ourselves to be calm while riding in an elevator by deliberately inducing a state of confidence and relaxation.

Example of Depression. For example, instead of talking about negative topics, and feeling more miserable and so thus depressing others, we could force (motivate) ourselves to talk about more pleasant or neutral topics, thereby increasing the likelihood of experiencing more uplifting feelings and thoughts.

Biochemical Factors

Secondly, there is the presence of a chemical imbalance of the neuro-transmitters (e.g., serotonine and nor-adrenaline) in the brain. This, in turn can negatively affect your thinking patterns, belief systems and coping abilities.

The above raises the age old question: What was first, the egg or the chicken? The truth is: The psychological and bio-chemical factors are so closely interlinked that they can't really be separated.

(ii) *What are the differences between Psychologists and Psychiatrists?*

Psychologist

Studies. A psychologist has at least a Master's Degree in Human Sciences and doesn't prescribe any medication. A psychologist has specialised in providing psychotherapy.

Different categories of specialisation within psychology. Clinical Psychologist; Counselling Psychologist; Education Psychologist; Industrial Psychologist.

Psychiatric problems. It is recommended that whenever you suffer from a Psychiatric Disorder such as depression or severe anxiety, you consult a Clinical Psychologist. A clinical psychologist is especially trained to diagnose and treat people with these kinds of problems.

Hospitalisation. Furthermore, in the event when you need hospitalisation, a clinical psychologist is allowed to admit and treat you, whereas the other psychologists are not allowed to do this.

Psychiatrist

A psychiatrist is a medical specialist who has specialised in psychiatry. They treat patients by using medical methods (e.g., medication or shock treatment), as well as psychotherapy.

(iii) *What is psychotherapy?*

Psychotherapy is viewed as a learning process and the psychotherapist as a teacher who teaches the patient more effective ways of thinking about themselves, others, and the world in general.

Depression and Anxiety. The treatment of choice is Cognitive-Behaviour Therapy and Neuro-Linguistic Programming. Both these therapeutic models focus on the solution of our problems, and are geared towards the future. Very little time is spent talking about the past. You'll be provided with step-by-step guidelines which will assist you in feeling and behaving in the way you would like to. The benefits are numerous, and include greater self-confidence, feeling in control, being more motivated, feeling more purposeful, and relaxed. One of the main interventions used is the answering of very powerful QUESTIONS.

☞TIP: INTRODUCE: FOCUS YOUR LIFE

Introduce some examples (two or three) of the below outlined questions – determine most relevant question to ask a particular member. Give the respondent some time to experience the impact of each question.

QUESTIONS: FOCUS YOUR LIFE

1. What are the five things you value most?
2. What are the three most important goals in your life right now?
3. What would you do if you won a million rand today?
4. Assuming you would be in perfect health, what would you do if you knew you had only 6 months to live?
5. What have you always wanted to do but were afraid to attempt?
6. What kind of activities make you feel best about yourself?
7. Imagine if you had one wish granted, what would it be?
8. What great thing would you give your life to if you were absolutely assured of success?

Determine the effect of question(s) A:

- *"Did any of these questions make you think?"*
- *"Did you arrive at some new insight about what is important to you in your life?"*
- *"Do you think that if you could achieve this new insight that you would be happier?"*

(iv) *What medication will I receive from my doctor?*

Anti-depressants

Although all of them are more or less equally effective in treating depressive symptoms, there are differences regarding unpleasant side-effects and the dangers involved in case of over-dosage.

"Older" medication such as Amitriptyline (Tryptanol), Clomipramine (Anafrinil) and Impramine (Tofranil) has more side effects (e.g., dry mouth and blurred vision) and is very dangerous in case of over-dosage.

"Newer" medication, such as Fluoxetine (Prozac), Paroxine (Aropax), has fewer side-effects and is not as dangerous in case of over-dosage.

Most andi-depressants take approximately two weeks before they start working effectively, and need to be taken for approximately six months.

Anxiety disorders

Anti-depressants can also be used in treating anxiety states (e.g., obsessive-compulsive disorder). The most effective medication in treating anxiety is "benzodiazepines", which are also used to treat sleeplessness. Examples are Alprazolam (Xanor), Clonazepam (Rivotril), Oxazepam (Serepax), Midazolam (Dormicum). Although very effective, these are habit forming. The implications are that patients need larger amounts, and when stopped, withdrawal symptoms develop.

Alternatives to "benzodiazepines" are medications such as Buspirone (Buspar) and Hydrozine (Aterax).

(v) *What is Electro-Convulsive Therapy (ECT)?*

ECT is predominantly used for severe and treatment-resistant depressions (depressions which didn't improve with medication). ECT produces a gradual improvement in mood and drive which enable the patient to think more positively as the treatment continues. ECT is not a permanent or overall "cure" for depression, and it is important that the person still continues to take prescribed medication and psychotherapeutic treatment.

ECT does however produce certain side-effects, such as headaches muscular pains, and a period of confusion (short period of time just after the person has regained consciousness). The most problematic side-effect is a memory problem, which refers to a loss of memory regarding the period during which the ECT is administered.

The extent of the memory loss differs from person to person. Some people seem to have no problems at all, while others will have forgotten everything that happened during their period of hospitalisation. It is important to realise that ECT doesn't wipe out your entire memory, nor does ECT cause any damage to the brain.

ECT is administered in a series of 6 to 12 treatments; usually during every second day. The procedure takes about 5 minutes, is painless, and takes place in a theatre in the presence of the psychiatrist and anaesthetist.

(vi) *How successful is treatment?*

Depression

Most depressions respond very well to treatment, and complete recovery is often the case. In severe cases the best form of treatment is often a combination of medication and psychotherapy, whereas the less severe depressions respond very well to psycho-therapeutical treatment and in most cases medication is not necessary.

Anxiety

Research has shown that medication alone provides relief for as long as the medication is taken; once stopped, in many instances, the anxiety returns.

However, psychotherapy is aimed at re-shaping the maladaptive thinking patterns and beliefs as well as increasing the level of coping skills, is superior to medication alone, in that, its beneficial effects can be experienced by the person for the rest of their life. Furthermore, psychotherapy doesn't produce any negative side-effects and takes place over a fairly short period of time – usually 20 or fewer sessions are sufficient.

Nonetheless, in many instances, the combined treatment of medication and psychotherapy is indicated.

<u>Brochures</u>

Two brochures are available, being "Relaxing about Anxiety" and "Uplifting Thoughts about Depression". Both these brochures are packed with information about anxiety and depression, and include information about the causes, the most commonly found symptoms, and interesting and stimulating guidelines which are of help in getting people on the road to emotional well-being.

Numerous experiments and useful tips have been included in the brochures. All of these have been subjected to research and have been found to be extremely effective in helping people who suffer from depression and anxiety.

It is important to inform the member that the experiments have been put in a specific sequence and that they should adhere to the outlined sequence in order to ensure maximum benefit.

Audiotapes

The audiotapes complement the brochures; for example, Relaxation Exercises which complement the brochure "Relaxing about Anxiety". The audiotapes have been written in a very specific language, which is referred to as the Milton Model.

The Milton Model

The Milton Model was developed after the work of Milton Erickson who was an excellent communicator and hypnotist. He used language in an artfully vague way so that his clients could take the meaning that was most appropriate for them. A further important part is the process where information is left out, so that the conscious mind can fill the gaps from its store of memories.

Becoming A Resourceful Help line Member

The chances are good that the outlined experiments, tips and counselling procedures are unfamiliar to you. If so, you are advised to "work your way" through the brochures and COMPLETE every experiment. This will provide you with inside information regarding the effect these experiments could have on your feelings, beliefs, and behaviour. The latter will be of great help when applying these. Furthermore, how would you be able to motivate others to apply these procedures if you don't REALLY know what their impact is?

However, COMPLETING these experiments and APPLYING them are two totally different matters. The latter can be achieved only by Experiential Learning during which a role-model models the correct application of these procedures.

Appendix

Add Member Material, Help line/Counselling Programme, and Evaluation of Treatment Progress (Progress Reports).

MAJOR PRE-SUPPOSITIONS OF NLP

As Richard Bandler used to say:

"These pre-suppositions are all lies. But if you believe in them, they work."

1. COMMUNICATION IS REDUNDANT.
   We always communicate in all 3 major representational systems.

2. THE MEANING OF YOUR COMMUNICATION IS THE RESPONSE THAT YOU GET.
   Communication is about having an outcome; e.g., building rapport. If you don't get the response you want, keep on changing your response until you reach your outcome.

3. PEOPLE RESPOND TO THEIR MAP OF REALITY, NOT TO REALITY ITSELF.

4. PEOPLE WORK PERFECTLY. NO ONE IS WRONG OR BROKEN.
   We all work towards achieving results. Although, the results we produce may not be what we want; and/or may not be good for others and/or ourselves.

5. PEOPLE ALWAYS MAKE THE BEST CHOICE AVAILABLE TO THEM AT THE TIME.

6. EVERY BEHAVIOUR IS USEFUL IN SOME CONTEXT.

7. CHOICE IS BETTER THAN NO CHOICE.

8. ANYONE CAN DO ANYTHING.
   If one person can do something, it is possible to model that and teach it to anyone.

9. PEOPLE ALREADY HAVE ALL ATHE RESOURCES THEY NEED.
10. THERE IS NO SUCH THING AS FAILURE, ONLY FEEDBACK.

11. CHUNKING.
    Anything can be accomplished if the task is broken down into small enough chunks.

12. REQUISITE VARIETY.

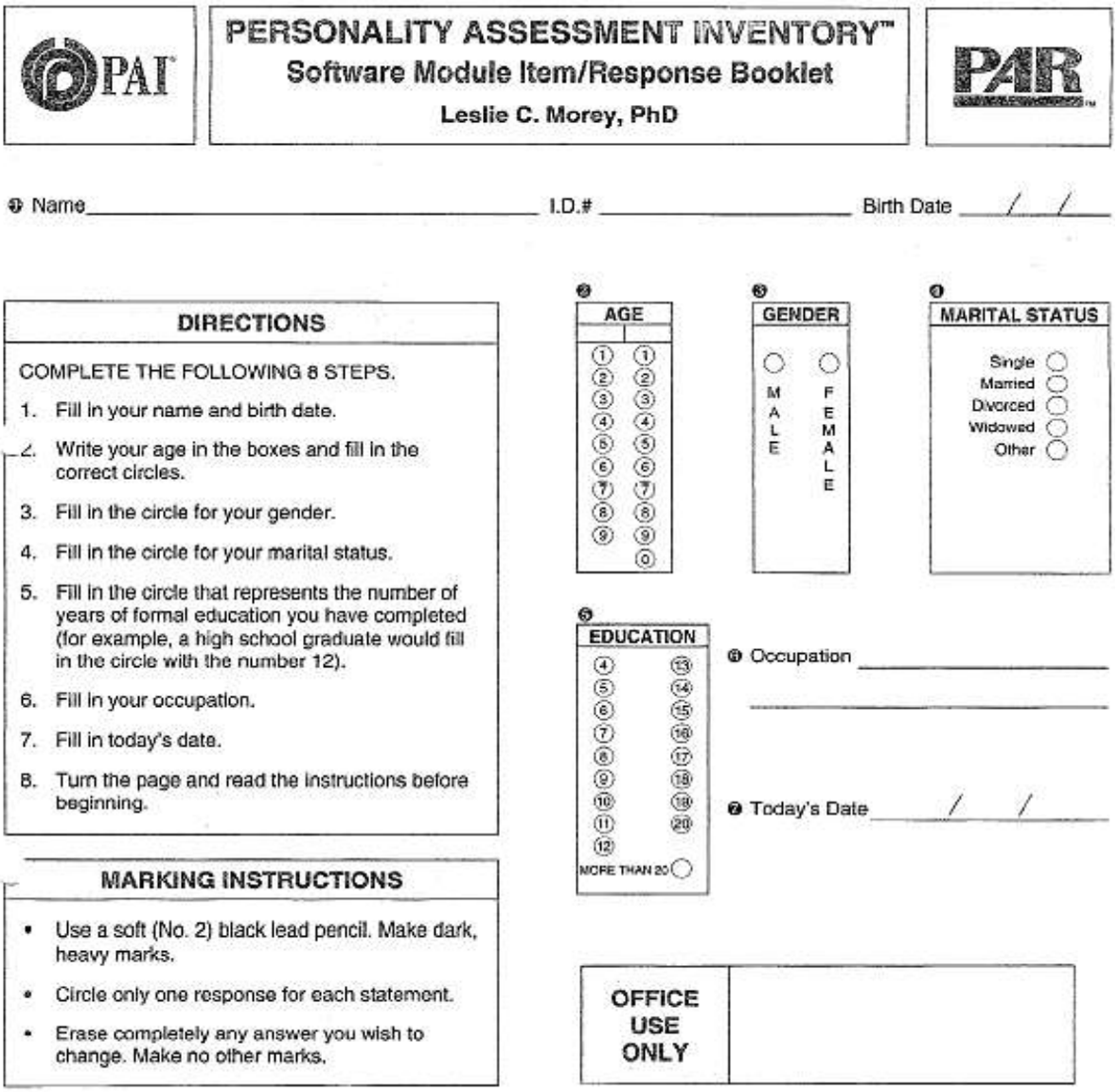
The element in a system with the most flexibility will be the controlling element.

13. IF YOU ALWAYS DO WHAT YOU'VE DONE, YOU'LL ALWAYS GET WHAT YOU'VE ALWAYS GOT. IF WHAT YOU ARE DOING IS NOT WORKING, DO SOMETHING ELSE.
    The more choices, the more success.

14. BEHIND EVERY BEHAVIOUR IS A POSITIVE INTENTION.

15. The more ways in which we can communicate, the greater will be our effectiveness in communication.

Appendix E



PERSONALITY ASSESSMENT INVENTORY™
Software Module Item/Response Booklet
Leslie C. Morey, PhD

❶ Name _____ I.D.# _____ Birth Date ___/___/___

DIRECTIONS

COMPLETE THE FOLLOWING 8 STEPS.

1. Fill in your name and birth date.
2. Write your age in the boxes and fill in the correct circles.
3. Fill in the circle for your gender.
4. Fill in the circle for your marital status.
5. Fill in the circle that represents the number of years of formal education you have completed (for example, a high school graduate would fill in the circle with the number 12).
6. Fill in your occupation.
7. Fill in today's date.
8. Turn the page and read the instructions before beginning.

MARKING INSTRUCTIONS

- Use a soft (No. 2) black lead pencil. Make dark, heavy marks.
- Circle only one response for each statement.
- Erase completely any answer you wish to change. Make no other marks.

❷ AGE

❸ GENDER — MALE / FEMALE

❹ MARITAL STATUS — Single, Married, Divorced, Widowed, Other

❺ EDUCATION — MORE THAN 20

❻ Occupation _____

❼ Today's Date ___/___/___

OFFICE USE ONLY

INSTRUCTIONS

Read each statement and decide whether it is an accurate statement about you.

- •If the statement is **FALSE, NOT AT ALL TRUE**, circle **F**.
- •If the statement is **MAINLY TRUE**, circle **MT**.
- •If the statement is **VERY TRUE**, circle **VT**.

Give your own opinion of yourself. Be sure to answer every statement. Statement Erase completely any answer you wish to change. Begin with the first statement and respond to everyone

	F = FALSE, NOT AT ALL TRUE, ST = SLIGHTLY TRUE, MT = MAINLY TRUE, VT = VERY TRUE				
1	My friends are available if I need them	**F**	**ST**	**MT**	**VT**
2	I have some inner struggles that cause problems for me	**F**	**ST**	**MT**	**VT**
3	My health condition has restricted my activities	**F**	**ST**	**MT**	**VT**
4	I am so tense in certain situations that I have great difficulty getting by	**F**	**ST**	**MT**	**VT**
5	I have to do some things a certain way of I get nervous	**F**	**ST**	**MT**	**VT**
6	Much of the time I'm sad for no real reason	**F**	**ST**	**MT**	**VT**
7	Often I think and talk so quickly that other people cannot follow my train of thought	**F**	**ST**	**MT**	**VT**
8	Most of the people I know can be trusted	**F**	**ST**	**MT**	**VT**
9	Sometimes I cannot remember who I am	**F**	**ST**	**MT**	**VT**
10	I have some ideas that others think are strange	**F**	**ST**	**MT**	**VT**
11	I was usually well-behaved at school	**F**	**ST**	**MT**	**VT**
12	I've seen a lot of doctors over the years	**F**	**ST**	**MT**	**VT**
13	I'm a very sociable person	**F**	**ST**	**MT**	**VT**
14	My mood can shift quite suddenly	**F**	**ST**	**MT**	**VT**
15	My mood can shift quite suddenly	**F**	**ST**	**MT**	**VT**
16	I'm a "take charge" type of person	**F**	**ST**	**MT**	**VT**
17	My attitude about myself changes a lot	**F**	**ST**	**MT**	**VT**
18	People would be surprised if I yelled at someone	**F**	**ST**	**MT**	**VT**
19	My relationships have been stormy	**F**	**ST**	**MT**	**VT**
20	At times I wish I were dead	**F**	**ST**	**MT**	**VT**
21	People are afraid of my temper	**F**	**ST**	**MT**	**VT**
22	Sometimes I use drugs to feel better	**F**	**ST**	**MT**	**VT**
23	I've tried just about every type of drug	**F**	**ST**	**MT**	**VT**
24	Sometimes I let little things bother me too much	**F**	**ST**	**MT**	**VT**
25	I often have trouble concentrating because I'm nervous	**F**	**ST**	**MT**	**VT**
26	I often fear I might slip up and say something wrong	**F**	**ST**	**MT**	**VT**
27	I feel that I've let everyone down	**F**	**ST**	**MT**	**VT**
28	I have many brilliant ideas	**F**	**ST**	**MT**	**VT**
29	Certain people go out of their way to bother me	**F**	**ST**	**MT**	**VT**

INSTRUCTIONS

Read each statement and decide whether it is an accurate statement about you.

- •If the statement is **FALSE, NOT AT ALL TRUE**, circle **F**.
- •If the statement is **MAINLY TRUE**, circle **MT**.
- •If the statement is **VERY TRUE**, circle **VT**.

Give your own opinion of yourself. Be sure to answer every statement. Statement Erase completely any answer you wish to change. Begin with the first statement and respond to everyone

	F = FALSE, NOT AT ALL TRUE, ST = SLIGHTLY TRUE, MT = MAINLY TRUE, VT = VERY TRUE				
30	I just don't seem to relate to people very well.	**F**	**ST**	**MT**	**VT**
31	I've borrowed money knowing I wouldn't pay it back	**F**	**ST**	**MT**	**VT**
32	Much of the time I don't feel well	**F**	**ST**	**MT**	**VT**
33	I often feel jittery	**F**	**ST**	**MT**	**VT**
34	I keep reliving something horrible that happened to me	**F**	**ST**	**MT**	**VT**
35	I hardly have any energy	**F**	**ST**	**MT**	**VT**
36	I can be very demanding when I want things done quickly	**F**	**ST**	**MT**	**VT**
37	People usually treat me pretty fairly	**F**	**ST**	**MT**	**VT**
38	My thinking has become confused	**F**	**ST**	**MT**	**VT**
39	I get a kick out of doing dangerous things	**F**	**ST**	**MT**	**VT**
40	My favorite poet is Raymond Kerecz	**F**	**ST**	**MT**	**VT**
41	I like being around my family	**F**	**ST**	**MT**	**VT**
42	I need to make some important changes in my life	**F**	**ST**	**MT**	**VT**
43	I've had illnesses that my doctors could not explain	**F**	**ST**	**MT**	**VT**
44	can't do some things well because of nervousness	**F**	**ST**	**MT**	**VT**
45	I have impulses that I fight to keep under control	**F**	**ST**	**MT**	**VT**
46	I've forgotten what it's like to feel happy	**F**	**ST**	**MT**	**VT**
47	I take on so many commitments that I can't keep up	**F**	**ST**	**MT**	**VT**
48	I have to be alert to the possibility that people will be unfaithful	**F**	**ST**	**MT**	**VT**
49	I have visions in which I see myself forced to commit crimes	**F**	**ST**	**MT**	**VT**
50	. Other people sometimes put thoughts into my head	**F**	**ST**	**MT**	**VT**
51	I've deliberately damaged someone's property	**F**	**ST**	**MT**	**VT**
52	My health problems are very complicated	**F**	**ST**	**MT**	**VT**
53	It's easy for me to make new friends	**F**	**ST**	**MT**	**VT**
54	My moods get quite intense	**F**	**ST**	**MT**	**VT**
55	I have trouble controlling my use of alcohol	**F**	**ST**	**MT**	**VT**
56	I'm a natural leader	**F**	**ST**	**MT**	**VT**
57	Sometimes I feel terribly empty inside	**F**	**ST**	**MT**	**VT**
58	I tell people off when they deserve it.	**F**	**ST**	**MT**	**VT**

INSTRUCTIONS

Read each statement and decide whether it is an accurate statement about you.

- •If the statement is **FALSE, NOT AT ALL TRUE**, circle **F**.
- •If the statement is **MAINLY TRUE**, circle **MT**.
- •If the statement is **VERY TRUE**, circle **VT**.

Give your own opinion of yourself. Be sure to answer every statement. Statement Erase completely any answer you wish to change. Begin with the first statement and respond to everyone

F = FALSE, NOT AT ALL TRUE,	ST = SLIGHTLY TRUE,	MT = MAINLY TRUE,	VT = VERY TRUE

59	I want to let certain people know how much they've hurt me	**F**	**ST**	**MT**	**VT**
60	I've thought about ways to kill myself	**F**	**ST**	**MT**	**VT**
61	Sometimes my temper explodes and I completely lose control	**F**	**ST**	**MT**	**VT**
62	People have told me that I have a drug problem	**F**	**ST**	**MT**	**VT**
63	I never use drugs to help me cope with the world	**F**	**ST**	**MT**	**VT**
64	Sometimes I'll avoid someone I really don't like	**F**	**ST**	**MT**	**VT**
65	It's often hard for me to enjoy myself because I am worrying about things	**F**	**ST**	**MT**	**VT**
66	I have exaggerated fears	**F**	**ST**	**MT**	**VT**
67	Sometimes I think I'm worthless	**F**	**ST**	**MT**	**VT**
68	I have some very special talents that few others have	**F**	**ST**	**MT**	**VT**
69	Some people do things to make me look bad	**F**	**ST**	**MT**	**VT**
70	I don't have much to say to anyone	**F**	**ST**	**MT**	**VT**
71	I'll take advantage of others if they leave themselves open to it	**F**	**ST**	**MT**	**VT**
72	. I suffer from a lot of pain	**F**	**ST**	**MT**	**VT**
73	I worry so much that at times I feel like I am going to faint	**F**	**ST**	**MT**	**VT**
74	Thoughts about my past often bother me while I'm thinking about something else	**F**	**ST**	**MT**	**VT**
75	I have no trouble falling asleep	**F**	**ST**	**MT**	**VT**
76	I get quite irritated if people try to keep me from accomplishing my goals	**F**	**ST**	**MT**	**VT**
77	I seem to have as much luck in life as others do	**F**	**ST**	**MT**	**VT**
78	My thoughts get scrambled sometimes	**F**	**ST**	**MT**	**VT**
79	I do a lot of wild things just for the thrill of it	**F**	**ST**	**MT**	**VT**
80	Sometimes I get ads in the mail that I don't really want	**F**	**ST**	**MT**	**VT**
81	If I'm having problems, I have people I can talk to	**F**	**ST**	**MT**	**VT**
82	I need to change some things about myself, even if it hurts	**F**	**ST**	**MT**	**VT**
83	I've had numbness in parts of my body that I can't explain	**F**	**ST**	**MT**	**VT**

INSTRUCTIONS

Read each statement and decide whether it is an accurate statement about you.

- •If the statement is **FALSE, NOT AT ALL TRUE**, circle **F**.
- •If the statement is **MAINLY TRUE**, circle **MT**.
- •If the statement is **VERY TRUE**, circle **VT**.

Give your own opinion of yourself. Be sure to answer every statement. Statement Erase completely any answer you wish to change. Begin with the first statement and respond to everyone

	F = FALSE, NOT AT ALL TRUE, ST = SLIGHTLY TRUE, MT = MAINLY TRUE, VT = VERY TRUE				
84	Sometimes I am afraid for no reason	**F**	**ST**	**MT**	**VT**
85	It bothers me when things are out of place	**F**	**ST**	**MT**	**VT**
86	Everything seems like a big effort	**F**	**ST**	**MT**	**VT**
87	Recently I've had much more energy than usual	**F**	**ST**	**MT**	**VT**
88	Most people have good intentions	**F**	**ST**	**MT**	**VT**
89	Since the day I was born, I was destined to be unhappy	**F**	**ST**	**MT**	**VT**
90	Sometimes it seems that my thoughts are broadcast so that others can hear them.	**F**	**ST**	**MT**	**VT**
91	I've done some things that weren't exactly legal	**F**	**ST**	**MT**	**VT**
92	It's a struggle for me to get things done with the medical problems I have	**F**	**ST**	**MT**	**VT**
93	I like to meet new people	**F**	**ST**	**MT**	**VT**
94	My mood is very steady	**F**	**ST**	**MT**	**VT**
95	There have been times when I've had to cut down on my drinking	**F**	**ST**	**MT**	**VT**
96	I would be good at a job where I tell others what to do	**F**	**ST**	**MT**	**VT**
97	I worry a lot about other people leaving me	**F**	**ST**	**MT**	**VT**
98	When I get mad at other drivers on the road, I let them know	**F**	**ST**	**MT**	**VT**
99	People once close to me have let me down	**F**	**ST**	**MT**	**VT**
100	I've made plans about how to kill myself	**F**	**ST**	**MT**	**VT**
101	Sometimes I'm very violent	**F**	**ST**	**MT**	**VT**
102	My drug use has caused me financial strain	**F**	**ST**	**MT**	**VT**
103	I've never had problems at work because of drugs	**F**	**ST**	**MT**	**VT**
104	I sometimes complain too much	**F**	**ST**	**MT**	**VT**
105	I'm often so worried and nervous that I can barely stand it	**F**	**ST**	**MT**	**VT**
106	I get very nervous when I have to do something in front of others	**F**	**ST**	**MT**	**VT**
107	I don't feel like trying anymore	**F**	**ST**	**MT**	**VT**
108	My plans will make me famous someday	**F**	**ST**	**MT**	**VT**
109	People around me are faithful to me	**F**	**ST**	**MT**	**VT**
110	I'm a loner	**F**	**ST**	**MT**	**VT**
111	I'll do most things if the price is right	**F**	**ST**	**MT**	**VT**

INSTRUCTIONS

Read each statement and decide whether it is an accurate statement about you.

- •If the statement is **FALSE, NOT AT ALL TRUE**, circle **F**.
- •If the statement is **MAINLY TRUE**, circle **MT**.
- •If the statement is **VERY TRUE**, circle **VT**.

Give your own opinion of yourself. Be sure to answer every statement. Statement Erase completely any answer you wish to change. Begin with the first statement and respond to everyone

	F = FALSE, NOT AT ALL TRUE, ST = SLIGHTLY TRUE, MT = MAINLY TRUE, VT = VERY TRUE				
112	I am in good health	**F**	**ST**	**MT**	**VT**
113	Sometimes I feel dizzy when I've been under a lot of pressure	**F**	**ST**	**MT**	**VT**
114	I've been troubles by memories of a bad experience for a long time	**F**	**ST**	**MT**	**VT**
115	I rarely have trouble sleeping	**F**	**ST**	**MT**	**VT**
116	Sometimes I get upset because others don't understand my plans	**F**	**ST**	**MT**	**VT**
117	I've given a lot, but I haven't gotten much in return	**F**	**ST**	**MT**	**VT**
118	Sometimes I have trouble keeping thoughts separate	**F**	**ST**	**MT**	**VT**
119	My behaviour is pretty wild at times	**F**	**ST**	**MT**	**VT**
120	My favourite sports event on television is high jump	**F**	**ST**	**MT**	**VT**
121	I spend most of my time alone	**F**	**ST**	**MT**	**VT**
122	I need some help to deal with important problems	**F**	**ST**	**MT**	**VT**
123	I've ad episodes of double vision or blurred vision	**F**	**ST**	**MT**	**VT**
124	I'm not the kind of person who panics easily	**F**	**ST**	**MT**	**VT**
125	I can relax even if my home is a mess	**F**	**ST**	**MT**	**VT**
126	Nothing seems to give me much pleasure	**F**	**ST**	**MT**	**VT**
127	At times my thoughts move very quickly	**F**	**ST**	**MT**	**VT**
128	I usually assume people are telling the truth	**F**	**ST**	**MT**	**VT**
129	I think I have three or four completely different personalities inside of me	**F**	**ST**	**MT**	**VT**
130	Others can read my thoughts	**F**	**ST**	**MT**	**VT**
131	I used to lie a lot to get out of tight situations	**F**	**ST**	**MT**	**VT**
132	My medical problems always seem to be hard to treat	**F**	**ST**	**MT**	**VT**
133	I am a warm person	**F**	**ST**	**MT**	**VT**
134	I have little control over my anger	**F**	**ST**	**MT**	**VT**
135	My drinking seems to cause problems in my relationships with others	**F**	**ST**	**MT**	**VT**
136	I have trouble standing up for myself	**F**	**ST**	**MT**	**VT**
137	I often wonder what I should do with my life	**F**	**ST**	**MT**	**VT**
138	I'm not afraid to yell at someone to get my point a cross	**F**	**ST**	**MT**	**VT**
139	I rarely feel very lonely	**F**	**ST**	**MT**	**VT**

INSTRUCTIONS

Read each statement and decide whether it is an accurate statement about you.

- •If the statement is **FALSE, NOT AT ALL TRUE**, circle **F**.
- •If the statement is **MAINLY TRUE**, circle **MT**.
- •If the statement is **VERY TRUE**, circle **VT**.

Give your own opinion of yourself. Be sure to answer every statement. Statement Erase completely any answer you wish to change. Begin with the first statement and respond to everyone

	F = FALSE, NOT AT ALL TRUE, ST = SLIGHTLY TRUE, MT = MAINLY TRUE, VT = VERY TRUE				
140	I've recently been thinking about suicide	**F**	**ST**	**MT**	**VT**
141	Sometimes I smash things when I'm upset	**F**	**ST**	**MT**	**VT**
142	I never use illegal drugs	**F**	**ST**	**MT**	**VT**
143	I sometimes do things so impulsively that I get into trouble	**F**	**ST**	**MT**	**VT**
144	Sometimes I'm too impatient	**F**	**ST**	**MT**	**VT**
145	My friends say I worry too much	**F**	**ST**	**MT**	**VT**
146	I'm not easily frightened	**F**	**ST**	**MT**	**VT**
147	I can't seem to concentrate very well	**F**	**ST**	**MT**	**VT**
148	I have accomplished some remarkable things	**F**	**ST**	**MT**	**VT**
149	Some people try to keep me from getting ahead	**F**	**ST**	**MT**	**VT**
150	I don't feel close to anyone	**F**	**ST**	**MT**	**VT**
151	I can talk my way out of just aout anything	**F**	**ST**	**MT**	**VT**
152	I seldom have complaints about how I feel physically	**F**	**ST**	**MT**	**VT**
153	I can often feel my heart pounding	**F**	**ST**	**MT**	**VT**
154	I can't seem to get over something from my past	**F**	**ST**	**MT**	**VT**
155	I've been moving more slowly than usual	**F**	**ST**	**MT**	**VT**
156	I have great plans and it irritates me that people try to interfere	**F**	**ST**	**MT**	**VT**
157	People don't appreciate what I've done for them	**F**	**ST**	**MT**	**VT**
158	Sometimes it feels as if somebody is blocking my thoughts	**F**	**ST**	**MT**	**VT**
159	If I get tired of a place, I just pick up and leave	**F**	**ST**	**MT**	**VT**
160	Most people would rather win than lose	**F**	**ST**	**MT**	**VT**
161	Most people I'm close to are very supportive	**F**	**ST**	**MT**	**VT**
162	I'm curious why I behave the way I do	**F**	**ST**	**MT**	**VT**
163	There have been times when my eyesight got worse and then betterr again	**F**	**ST**	**MT**	**VT**
164	I an a very calm and relaxed person	**F**	**ST**	**MT**	**VT**
165	People say that I'm a perfectionist	**F**	**ST**	**MT**	**VT**
166	I've lost interest in things I used to enjoy	**F**	**ST**	**MT**	**VT**
167	My friends can't keep up with social activities	**F**	**ST**	**MT**	**VT**
168	People generally hide their real motives	**F**	**ST**	**MT**	**VT**

INSTRUCTIONS

Read each statement and decide whether it is an accurate statement about you.

- •If the statement is **FALSE, NOT AT ALL TRUE**, circle **F**.
- •If the statement is **MAINLY TRUE**, circle **MT**.
- •If the statement is **VERY TRUE**, circle **VT**.

Give your own opinion of yourself. Be sure to answer every statement. Statement Erase completely any answer you wish to change. Begin with the first statement and respond to everyone

	F = FALSE, NOT AT ALL TRUE, ST = SLIGHTLY TRUE, MT = MAINLY TRUE, VT = VERY TRUE				
169	People don't understand how much I suffer	**F**	**ST**	**MT**	**VT**
170	I've heard voices that no one else can hear	**F**	**ST**	**MT**	**VT**
171	I like to see how much I can ge away with	**F**	**ST**	**MT**	**VT**
172	I've had only the usual health problems that most peole have	**F**	**ST**	**MT**	**VT**
173	It takes me a while to warm up to people	**F**	**ST**	**MT**	**VT**
174	I've always been a pretty happy person	**F**	**ST**	**MT**	**VT**
175	Drinking helps me get along in socila situations	**F**	**ST**	**MT**	**VT**
176	I feel vest in situations where I am the leader	**F**	**ST**	**MT**	**VT**
177	I can't handle separation from those close to me verry well	**F**	**ST**	**MT**	**VT**
178	I always avoid arguments if I can	**F**	**ST**	**MT**	**VT**
179	I've made some real mistakes in the people I've picked up as friends	**F**	**ST**	**MT**	**VT**
180	I have thought about suicide for a long time	**F**	**ST**	**MT**	**VT**
181	I've threatened to hurt people	**F**	**ST**	**MT**	**VT**
182	I've used prescription drugs to get high	**F**	**ST**	**MT**	**VT**
183	When I'm upset, I typically do something to hurt myself	**F**	**ST**	**MT**	**VT**
184	I don't take criticism very well	**F**	**ST**	**MT**	**VT**
185	I don't worry about things any more than most people	**F**	**ST**	**MT**	**VT**
186	I don't mind driving on freeways	**F**	**ST**	**MT**	**VT**
187	No matter what I do, nothing works	**F**	**ST**	**MT**	**VT**
188	I think I have the answers to some very important questions	**F**	**ST**	**MT**	**VT**
189	There are people who want to hurt me	**F**	**ST**	**MT**	**VT**
190	I enjoy the company of other people	**F**	**ST**	**MT**	**VT**
191	I don't like being tied to one person	**F**	**ST**	**MT**	**VT**
192	I have a bad back	**F**	**ST**	**MT**	**VT**
193	It's easy for me to relax	**F**	**ST**	**MT**	**VT**
194	I have had some horrible experiences that make me feel guilty	**F**	**ST**	**MT**	**VT**
195	I often wake up very early in the morning and can't go back to sleep	**F**	**ST**	**MT**	**VT**

INSTRUCTIONS

Read each statement and decide whether it is an accurate statement about you.

- •If the statement is **FALSE, NOT AT ALL TRUE**, circle **F**.
- •If the statement is **MAINLY TRUE**, circle **MT**.
- •If the statement is **VERY TRUE**, circle **VT**.

Give your own opinion of yourself. Be sure to answer every statement. Statement Erase completely any answer you wish to change. Begin with the first statement and respond to everyone

F = FALSE, NOT AT ALL TRUE,	ST = SLIGHTLY TRUE,	MT = MAINLY TRUE,	VT = VERY TRUE

196	It bothers me when other people are too slow to understand my ideas	**F**	**ST**	**MT**	**VT**
197	Usually I've gotten credit for what I've done	**F**	**ST**	**MT**	**VT**
198	My thoughts ted to quickly shift around to different things	**F**	**ST**	**MT**	**VT**
199	The idea of "settling down" had neverr appealed to me	**F**	**ST**	**MT**	**VT**
200	My favourite hobbies are archery and stamp-collecting	**F**	**ST**	**MT**	**VT**
201	People I know care about me	**F**	**ST**	**MT**	**VT**
202	I'm comfortable with myself the way I am	**F**	**ST**	**MT**	**VT**
203	I've had episodes when I've lost the feeling in my hands	**F**	**ST**	**MT**	**VT**
204	I often feel as if something terrible is about to happen	**F**	**ST**	**MT**	**VT**
205	I'm usually aware of objects that have a lot of germs	**F**	**ST**	**MT**	**VT**
206	I have no interest in life	**F**	**ST**	**MT**	**VT**
207	I feel like I need to keep active and not rest	**F**	**ST**	**MT**	**VT**
208	People think I'm too suspicious	**F**	**ST**	**MT**	**VT**
209	every once in a while I totally lose my memory	**F**	**ST**	**MT**	**VT**
210	There are people who try to control my thoughts	**F**	**ST**	**MT**	**VT**
211	I was never expelled or suspended from school when I was young	**F**	**ST**	**MT**	**VT**
212	I've had some unusual diseases and illnesses	**F**	**ST**	**MT**	**VT**
213	It takes a while for people to get to know me	**F**	**ST**	**MT**	**VT**
214	I've had times when I was so mad I couldn't do enough to express all my anger	**F**	**ST**	**MT**	**VT**
215	Some people around me think I drink too much alcohol	**F**	**ST**	**MT**	**VT**
216	I prefer to let others make decisions	**F**	**ST**	**MT**	**VT**
217	I don't get bored very easily	**F**	**ST**	**MT**	**VT**
218	I don't like raising my voice	**F**	**ST**	**MT**	**VT**
219	Once someone is my friend, we stay friends	**F**	**ST**	**MT**	**VT**
220	Death would be a relief	**F**	**ST**	**MT**	**VT**
221	I've never started a physical fight as an adult	**F**	**ST**	**MT**	**VT**
222	My drug use is out of control	**F**	**ST**	**MT**	**VT**
223	I'm too impulsive for my own good	**F**	**ST**	**MT**	**VT**
224	Sometimes I put things off until the last minute	**F**	**ST**	**MT**	**VT**

INSTRUCTIONS

Read each statement and decide whether it is an accurate statement about you.

- •If the statement is **FALSE, NOT AT ALL TRUE**, circle **F**.
- •If the statement is **MAINLY TRUE**, circle **MT**.
- •If the statement is **VERY TRUE**, circle **VT**.

Give your own opinion of yourself. Be sure to answer every statement. Statement Erase completely any answer you wish to change. Begin with the first statement and respond to everyone

	F = FALSE, NOT AT ALL TRUE, ST = SLIGHTLY TRUE, MT = MAINLY TRUE, VT = VERY TRUE				
225	I don't worry about things that I can't control	**F**	**ST**	**MT**	**VT**
226	I don't mind heights	**F**	**ST**	**MT**	**VT**
227	I think good things will happen to me in the future	**F**	**ST**	**MT**	**VT**
228	I think I would be a good comedian	**F**	**ST**	**MT**	**VT**
229	People seldom treat me badly on purpose	**F**	**ST**	**MT**	**VT**
230	I like to be around other people if I can	**F**	**ST**	**MT**	**VT**
231	I don't like to stay in a relationship very long	**F**	**ST**	**MT**	**VT**
232	I have a weak stomach	**F**	**ST**	**MT**	**VT**
233	When I'm under a lot of pressure, I sometimes have trouble breathing	**F**	**ST**	**MT**	**VT**
234	I keep having nightmares about my past	**F**	**ST**	**MT**	**VT**
235	I have a good appetite	**F**	**ST**	**MT**	**VT**
236	I have no patience with people who try to hold me back	**F**	**ST**	**MT**	**VT**
237	People who successful generally earned their success	**F**	**ST**	**MT**	**VT**
238	Sometimes I wonder if my thoughts are being taken away	**F**	**ST**	**MT**	**VT**
239	I like to drive fast	**F**	**ST**	**MT**	**VT**
240	I don't like to have to buy things that are over priced	**F**	**ST**	**MT**	**VT**
241	In my family, we argue more than we talk	**F**	**ST**	**MT**	**VT**
242	Many of my problems are my own doing	**F**	**ST**	**MT**	**VT**
243	I've had times when my legs became so weak I couldn't walk	**F**	**ST**	**MT**	**VT**
244	I seldom feel anxious or tense	**F**	**ST**	**MT**	**VT**
245	People see me as a person who pays a lot of attention to details	**F**	**ST**	**MT**	**VT**
246	Lately I've been happy much of the time	**F**	**ST**	**MT**	**VT**
247	Recently I have needed less sleep than usual	**F**	**ST**	**MT**	**VT**
248	Things are rarely as they seem on the surface	**F**	**ST**	**MT**	**VT**
249	Sometimes my vision is only in black and white	**F**	**ST**	**MT**	**VT**
250	I have a sixth sense that tells me what is going to happen	**F**	**ST**	**MT**	**VT**
251	I've never been in trouble with the law	**F**	**ST**	**MT**	**VT**
252	For my age, my health is pretty good	**F**	**ST**	**MT**	**VT**
253	I try to include people who seem left out	**F**	**ST**	**MT**	**VT**

INSTRUCTIONS

Read each statement and decide whether it is an accurate statement about you.

- •If the statement is **FALSE, NOT AT ALL TRUE**, circle **F**.
- •If the statement is **MAINLY TRUE**, circle **MT**.
- •If the statement is **VERY TRUE**, circle **VT**.

Give your own opinion of yourself. Be sure to answer every statement. Statement Erase completely any answer you wish to change. Begin with the first statement and respond to everyone

	F = FALSE, NOT AT ALL TRUE, ST = SLIGHTLY TRUE, MT = MAINLY TRUE, VT = VERY TRUE				
254	Sometimes I have an alcoholic drink in the morning	**F**	**ST**	**MT**	**VT**
255	My drinking has caused me problems at home	**F**	**ST**	**MT**	**VT**
256	I say what's on my mind	**F**	**ST**	**MT**	**VT**
257	I usually do what other people tell me to do	**F**	**ST**	**MT**	**VT**
258	I have a bad temper	**F**	**ST**	**MT**	**VT**
259	It takes a lot to make me angry	**F**	**ST**	**MT**	**VT**
260	I've thought about what I would say in a suicide note	**F**	**ST**	**MT**	**VT**
261	I can't think of reasons to go on living	**F**	**ST**	**MT**	**VT**
262	I've had health problems because of my drug use	**F**	**ST**	**MT**	**VT**
263	I spend money too easily	**F**	**ST**	**MT**	**VT**
264	I sometimes make promises I can't keep	**F**	**ST**	**MT**	**VT**
265	I usually worry about things more than I should	**F**	**ST**	**MT**	**VT**
266	I will not ride in airplanes	**F**	**ST**	**MT**	**VT**
267	I have something worthwhile to contribute	**F**	**ST**	**MT**	**VT**
268	Lately I feel so confident that I think I can accomplish anything	**F**	**ST**	**MT**	**VT**
269	People have had it in for me	**F**	**ST**	**MT**	**VT**
270	I make friends easily	**F**	**ST**	**MT**	**VT**
271	I look after myself first, let others take care of themselves	**F**	**ST**	**MT**	**VT**
272	I get more headaches that most people	**F**	**ST**	**MT**	**VT**
273	I get sweaty hands often	**F**	**ST**	**MT**	**VT**
274	Since I had a very bad experience, I am no longer interested in some things I used to enjoy	**F**	**ST**	**MT**	**VT**
275	I often wake up in the middle of the night	**F**	**ST**	**MT**	**VT**
276	At times I am very touchy and easily annoyed	**F**	**ST**	**MT**	**VT**
277	I'm not the type of person to hold a grudge	**F**	**ST**	**MT**	**VT**
278	Thoughts in my head suddenly disappear	**F**	**ST**	**MT**	**VT**
279	I'm not a person who turns down a dare	**F**	**ST**	**MT**	**VT**
280	Most people look forward to a trip to the dentist	**F**	**ST**	**MT**	**VT**
281	I spend little time with my family	**F**	**ST**	**MT**	**VT**
282	I can solve my problems by myself	**F**	**ST**	**MT**	**VT**
283	At times parts of my body have been paralyzed	**F**	**ST**	**MT**	**VT**

INSTRUCTIONS

Read each statement and decide whether it is an accurate statement about you.

- •If the statement is **FALSE, NOT AT ALL TRUE**, circle **F**.
- •If the statement is **MAINLY TRUE**, circle **MT**.
- •If the statement is **VERY TRUE**, circle **VT**.

Give your own opinion of yourself. Be sure to answer every statement. Statement Erase completely any answer you wish to change. Begin with the first statement and respond to everyone

	F = FALSE, NOT AT ALL TRUE, ST = SLIGHTLY TRUE, MT = MAINLY TRUE, VT = VERY TRUE				
284	I am easily startled	**F**	**ST**	**MT**	**VT**
285	I keep myself under tight control	**F**	**ST**	**MT**	**VT**
286	I 'm almost always a happy and positive person	**F**	**ST**	**MT**	**VT**
287	I hardly ever buy things on impulse	**F**	**ST**	**MT**	**VT**
288	People have to earn my trust	**F**	**ST**	**MT**	**VT**
289	I don't have any good memories from my childhood	**F**	**ST**	**MT**	**VT**
290	I don't believe that there are people who can read minds	**F**	**ST**	**MT**	**VT**
291	I've never taken money or property that wasn't mine	**F**	**ST**	**MT**	**VT**
292	I like to talk with people about their medical problems	**F**	**ST**	**MT**	**VT**
293	I'm an affectionate person	**F**	**ST**	**MT**	**VT**
294	I never drive when I've been drinking hardly ever drink alcohol	**F**	**ST**	**MT**	**VT**
295	I hardly ever drink alcohol	**F**	**ST**	**MT**	**VT**
296	People listen to my opinions	**F**	**ST**	**MT**	**VT**
297	If I get poor service from a business, I let the manager know about it	**F**	**ST**	**MT**	**VT**
298	My temper never gets me into trouble	**F**	**ST**	**MT**	**VT**
299	My anger never gets out of control	**F**	**ST**	**MT**	**VT**
300	I've thought about how others would react if I killed myself	**F**	**ST**	**MT**	**VT**
301	I have a lot to live for	**F**	**ST**	**MT**	**VT**
302	My best friends are those I use drugs with	**F**	**ST**	**MT**	**VT**
303	I'm a reckless person	**F**	**ST**	**MT**	**VT**
304	There have been times when I could have been more thoughtful than I was	**F**	**ST**	**MT**	**VT**
305	Sometimes I get so nervous that I'm afraid I'm going to die	**F**	**ST**	**MT**	**VT**
306	I don't mind traveling in a bus or train	**F**	**ST**	**MT**	**VT**
307	I'm pretty successful at what I do	**F**	**ST**	**MT**	**VT**
308	I could never imagine myself being famous	**F**	**ST**	**MT**	**VT**
309	I'm the target of a conspiracy	**F**	**ST**	**MT**	**VT**
310	I keep in touch with my friend	**F**	**ST**	**MT**	**VT**
311	When I make a promise, I really don' need to keep it	**F**	**ST**	**MT**	**VT**
312	I frequently have diarrhoea	**F**	**ST**	**MT**	**VT**

INSTRUCTIONS

Read each statement and decide whether it is an accurate statement about you.

- •If the statement is **FALSE, NOT AT ALL TRUE**, circle **F**.
- •If the statement is **MAINLY TRUE**, circle **MT**.
- •If the statement is **VERY TRUE**, circle **VT**.

Give your own opinion of yourself. Be sure to answer every statement. Statement Erase completely any answer you wish to change. Begin with the first statement and respond to everyone

	F = FALSE, NOT AT ALL TRUE, ST = SLIGHTLY TRUE, MT = MAINLY TRUE, VT = VERY TRUE				
313	I have very steady hands	**F**	**ST**	**MT**	**VT**
314	I avoid certain things that bring back bad memories	**F**	**ST**	**MT**	**VT**
315	I have little interest in sex	**F**	**ST**	**MT**	**VT**
316	I have little patience with those who disagree with my plans	**F**	**ST**	**MT**	**VT**
317	Being helpful to other people pays off in the end	**F**	**ST**	**MT**	**VT**
318	I can concentrate now as well as I ever could	**F**	**ST**	**MT**	**VT**
319	I never take risks if I can avoid it	**F**	**ST**	**MT**	**VT**
320	In my free time I might read, watch TV or just relax	**F**	**ST**	**MT**	**VT**
321	I have a lot of money problems	**F**	**ST**	**MT**	**VT**
322	My life is very unpredictable	**F**	**ST**	**MT**	**VT**
323	There have been many changes in my life recently	**F**	**ST**	**MT**	**VT**
324	there isn't much stability at home	**F**	**ST**	**MT**	**VT**
325	Things are not going well in my family	**F**	**ST**	**MT**	**VT**
326	I'm happy with my job situation	**F**	**ST**	**MT**	**VT**
327	I worry about having enough money to get by	**F**	**ST**	**MT**	**VT**
328	My relationship with my spouse or partner is not going well	**F**	**ST**	**MT**	**VT**
329	I have severe psychological problems that began very suddenly	**F**	**ST**	**MT**	**VT**
330	I'm a sympathetic person	**F**	**ST**	**MT**	**VT**
331	Close relationships are important to me	**F**	**ST**	**MT**	**VT**
332	I'm very impatient with people	**F**	**ST**	**MT**	**VT**
333	I have more friends than most people I know	**F**	**ST**	**MT**	**VT**
334	My drinking had never gotten me into trouble	**F**	**ST**	**MT**	**VT**
335	My drinking has cause problems with my work	**F**	**ST**	**MT**	**VT**
336	I don't like letting people know when I disagree with them	**F**	**ST**	**MT**	**VT**
337	I'm a very independent person	**F**	**ST**	**MT**	**VT**
338	When I get mad, it's hard for me to calm down	**F**	**ST**	**MT**	**VT**
339	people think I'm aggressive	**F**	**ST**	**MT**	**VT**
340	I'm considering suicide	**F**	**ST**	**MT**	**VT**
341	things have never been so bad that I thought about suicide	**F**	**ST**	**MT**	**VT**

INSTRUCTIONS

Read each statement and decide whether it is an accurate statement about you.

- •If the statement is **FALSE, NOT AT ALL TRUE**, circle **F**.
- •If the statement is **MAINLY TRUE**, circle **MT**.
- •If the statement is **VERY TRUE**, circle **VT**.

Give your own opinion of yourself. Be sure to answer every statement. Statement Erase completely any answer you wish to change. Begin with the first statement and respond to everyone

F = FALSE, NOT AT ALL TRUE,	ST = SLIGHTLY TRUE,	MT = MAINLY TRUE,	VT = VERY TRUE

342	My drug used had never caused problems with my family or friends	**F**	**ST**	**MT**	**VT**
343	I'm careful about how I spend my money	**F**	**ST**	**MT**	**VT**
344	I rarely get in a bad mood	**F**	**ST**	**MT**	**VT**

PLEASE SIGN AND COMPLETE THE ATTACHED FORM. THIS IS NEED FOR MEDICAL AID PURPOSES. YOUR CO-OPERATION IS HIGHLY APPRECIATED. THANK YOU VERY MUCH

Appendix F: Wellness