Spiritual Wellness, Holistic Health, and the Practice of Health Education

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ABSTRACT

The current practice of health education often fails to harmonize with the multidimensional, dynamic, and functional nature of health as generally defined within our profession. As a stepchild of the medical and public health professions, we have inherited a preoccupation with physical health as the most worthy outcome measure for most of our programs. Yet other dimensions of health seem equally important and even essential to the overall well-being of program participants. There exists an opportunity for health educators to move toward models of health promotion that more fully appreciate the interconnectedness of various dimensions of health and that promote them evenhandedly. This article argues that spiritual health is an underlying dimension that contributes to social and emotional health, which in turn provide motivation for health behavior changes that determine physical and intellectual health. To the degree attained, physical and intellectual health become tools for realizing the purpose and meaning in life that the spiritual worldview portrays. Practical application of this model requires a partial break from the biological orientations of other health professions, new research agendas that clarify multidimensional health relationships, and new educational approaches that are capable of promoting positive outcomes in a variety of health dimensions.

Seeking to climb stairs in the dark, on a staircase with missing or unequal treads, is a recipe for bruised shins and thwarted ascension. Just so, it is the argument of this article that the attainment of health education objectives is being hampered by a lack of appreciation for the functional role of spiritual wellness—a tread that is currently misaligned in the stairway of effective health education. This position is clarified by reviewing the definitions and goals of health education, considering philosophical inconsistencies in current practice, and outlining a foundational role for spiritual health education, that, if actualized, may improve the likelihood of successful outcomes.

THE UNREACHABLE GOAL OF HEALTH EDUCATION

It is the general goal of health education to improve the health knowledge and attitudes of individuals and thereby inspire personal behaviors that lead to optimal health and wellness, or high levels of functioning in all of the various dimensions of health (Butler, 2001). Underlying this goal are several assumptions or beliefs about the nature of health. First, *health* is typically defined in our literature as being multidimensional, the realization of which requires a degree of depth and balance among such

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diverse elements as physical health, emotional health, intellectual health, social health, and spiritual health (Cottrell, Girvan, & McKenzie, 2002). Further, these dimensions are considered to be dynamic inasmuch as the status of one dimension often influences the condition of another (Butler, 2001). Finally, it is argued that health is functional because most people value it primarily for its usefulness in the pursuit of higher aims, rather than merely as an end in itself (Read, 1997).

And yet the profession of health education seems philosophically inconsistent in its methodology, in that efforts at health promotion often ignore all three of the concepts presented in the preceding definition. First, the multidimensional nature of health is effectively discounted; most published health education objectives include only physical health variables as primary outcome measures (e.g., *Healthy People 2010*). Outside of educational settings that offer courses on personal health, it is difficult to identify more than a few health education interventions that target, say, intellectual health, social health, or spiritual health as principal dimensions of interest with specific outcome objectives. Why bother to comment on the multidimensional nature of health if in most settings we overlook all dimensions save one?

If the multidimensional nature of health is disregarded, then its dynamic nature can hardly be appreciated or capitalized on. Although it is well documented, for example, that emotional well-being exerts a profound influence on cardiovascular health, we do not often consider emotional health variables as outcome goals for cardiovascular prevention programs (Williams et al., 1999). Similarly, social support is a significant factor in understanding a multitude of health outcomes, including various types of cancer, cardiovascular disease, immune function (Callaghan & Morrissey, 1993; Uchino, Cacioppo, & Kiecolt-Glaser, 1996), women's health (Hurdle, 2001), and positive health practices (McNicholas, 2002). And spiritual well-being influences such diverse outcomes as recovery from addiction (Pardini, Plante,

Sherman, & Stump, 2000), teen sexual activity (Holder et al., 2000), depression (Nelson, Rosenfeld, Breitbart, & Galietta, 2002), eating disorders (Hawks, Goudy, & Gast, 2003), breast cancer (Feher & Maly, 1999), long survival with AIDS (Ironson et al., 2002), and a number of health behaviors (Waite, Hawks, & Gast, 1999). Yet, with few exceptions (e.g. Weaver & Cotrell, 1996; White & Dorman, 2001), health educators seldom attempt to measure or influence social health or spirituality in health education interventions. Without an appreciation of multidimensionality, we are unable to investigate the dynamic nature of these health dimensions in terms of how they interrelate with and impact one another (Karren, Hafen, Smith, & Frandsen, 2002).

Instead physical health is generally promoted by health educators as a sufficient end in itself, with no consideration for some larger purpose that might justify its need in the first place. The functional nature of health, its basic role of serving higher human interests, is thus lost in a fervor of physical health promotion, which implies that good physical health is apparently the greatest achievement possible. In contrast, it seems likely that most individuals become interested in improving health behaviors only when they see a vital connection between enhanced health status and the realization of a self-defined, higher purpose in life (Hawks, 1994; Hawks, Hull, Thalman, & Richins, 1995).

Consider the overweight, middle-aged, divorced gentleman, hopelessly entangled in a dead-end career, who spends inordinate amounts of time on the couch in front of the TV—eating chips, smoking cigarettes, drinking beer, and feeling sorry about his lonely and meaningless existence. In fact, he believes that his TV, stimulants, and snacks are the only things that make his otherwise unbearable life somewhat tolerable. How will this good man respond to the modern health educator who—without stopping to consider the various dimensions of health involved (e.g., social, emotional, spiritual, intellectual), and without contemplating the general lack of purpose in this

person's life—enthusiastically promotes dietary restraint, nicotine patches, and treadmills as the path to good physical health? Our client will likely roll his eyes with boredom, dismiss the notion of "health" altogether, and reach for another smoke.

And thus by failing to equitably consider and promote all dimensions of health, and without appreciating the true motivation that must underlie successful health behavior change—active engagement in a self-defined higher purpose—the realization of health education goals is substantially hindered. Indeed, as currently promoted, the primary goal of health education (substantial health behavior change at the population level) may be largely unreachable.

INCONSISTENCIES IN THEORY AND PRACTICE

Our preoccupation with physical health is not hard to understand given the foundational influence of the 17th century Cartesian duality that firmly separated mind and body (Gorham, 1994; Tomaselli, 1984). The subsequent development of physical medicine, and the later emergence of public health and health education professions that primarily target the prevention of physical illness, was perhaps inevitable (Rubin & Wessely, 2001; Switankowsky, 2000). The national health objectives for most developed nations (e.g., *Healthy People 2010*), and thus their public health funding mechanisms, continue to revolve almost exclusively around the prevention and treatment of physical illness (U.S. Department of Health and Human Services [USDHHS], 2000). Acceptance of this paradigm on the part of our profession implies the belief that if we simply take care of physical health, the apparently lesser dimensions will fall into place of their own accord. Or, if necessary, the clergy, psychologists, and social workers can tend to the emotional, social, spiritual, and intellectual maladies of humanity.

Such a one-dimensional, fractured approach is inconsistent with our philosophical allegiance to holistic health promotion (Switankowsky, 2000). We now have firm evidence that the mind and body, far from

being separate, are intimately interwoven—and that there truly are many dimensions of health that interact with each other (Karren et al., 2002). Therefore, it is less effective, if not negligent, to promote physical health without simultaneously addressing the other dimensions of health in a truly integrative model (Grace, 1998).

As it now stands our practice is inconsistent with our philosophy, and our effectiveness may be limited as a result. If things continue as they are, then ethically we must take a step backward and redefine health as consisting of a single static dimension that represents an end in itself (physical health). Alternatively, we might relabel our profession as that of physical health educator with a disclaimer that the complexity of multidimensional health cannot be promoted by a single discipline (at least, not by ours). Then again, we might rise to the occasion by fully embracing our current definition of health, initiating research agendas that help us understand the interconnectedness of all dimensions of health, and devising theory-based educational programs that might advance them evenhandedly.

BARRIERS TO PROMOTING MULTIDIMENSIONAL WELLNESS

There are several barriers that hinder progress toward a health education practice that genuinely promotes a dynamic, multidimensional wellness from a functional perspective. Perhaps the most daunting barrier is the inertia of a vast public health system that has settled around the focal point of physical health as the ultimate outcome objective. Physical health is tangible, understandable, measurable, and objective—and it is therefore easy to target. Given this reality, national physical health objectives that drive funding and other resource allocation mechanisms place inescapable pressure on health educators to pursue agendas that are consistent with those objectives (USDHHS, 2000).

A second barrier is the ambiguity of dealing with dimensions of health that have not achieved a consensus definition, are intangible, and are seemingly immeasurable.

One introductory health education text, for example, presents a standard overview of the five dimensions of health but concludes that the meaning of spiritual health must "be left to the individual reader" (Cottrell et al., 2002, p. 7). As opposed to this hopeless ambiguity, each dimension of health must be acceptably defined, operationalized, and have a means of valid, reliable measurement, so that it can become a legitimate outcome goal for health education programming. This has yet to happen for many of the core dimensions of health. Most aspects of the physical dimension, by contrast, have already achieved this status (e.g., blood pressure, blood lipid profiles, morbidity and mortality rates, body mass index), thereby contributing to the preponderance of research and practice that focuses on the physical dimension.

Finally, the trepidation of stepping into such politically charged arenas as the promotion of spirituality leaves the profession hesitant in acting on its own definition of health. One school health educator complained to the author that use of the word *condom* in a public secondary school classroom posed far fewer ramifications than use of the word *spirituality*. Even though it seems clear that spirituality can be promoted without violating the separation of church and state (Weaver & Cotrell, 1996), discomfort with this dimension remains even higher than other controversial arenas such as sexuality education.

OVERCOMING BARRIERS

Several steps have to be taken to bring the practice of health education into harmony with its philosophical foundations. The first step is to pursue organized efforts, possibly within the context of professional associations, to clearly define the various dimensions of health in a way that builds consensus. Numerous scholarly articles have been written about the nature of spiritual health (Banks, 1980; Bensley, 1991a, 1991b; Chapman, 1986; Hawks et al., 1995; Seaward, 1995), but a lack of professional consensus forces readers of introductory texts to come to their own conclusions as

to what it really represents and whether it is important. The recent process used to bring about consensus in relation to a professional code of ethics might represent a useful pattern for defining each health dimension (Cottrell et al., 2002). Likewise, previous efforts by jointly established committees to achieve consensus in health education standards and terminology might offer another plausible approach (Joint Committee on Health Education Standards, 1995; Joint Committee on Health Education Terminology, 1991).

The second step, also pursuable through the avenue of organized efforts by professional associations, is to place pressure on the crafters of national health objectives to develop public health objectives that represent a dynamic, multidimensional view of health. They should be encouraged further to design a stronger mechanism for increased local control over resource allocation that might include intervention and evaluation priorities that target nonphysical dimensions of health. Although the value of *Healthy People 2010* cannot be overestimated in terms of its ability to focus multilevel efforts on urgent problems (Cottrell et al., 2002), the process that leads to national objectives can be criticized as being too top-down in its orientation and too focused on the physical dimension of health.

Finally, there is a real need for individual health education researchers who are willing to commit time and energy to designing, implementing, and evaluating the impact of programs that target various nonphysical dimensions of health. Ideally, such a research agenda would lead to valid, reliable measures of these dimensions that include both quantitative and qualitative instruments and methodologies (Hawks et al., 1995). In 1990 J. R. Bloom challenged medical care researchers to develop a body of knowledge in relation to social support and health (Bloom, 1990). Within a few years dozens of research reports were published that clearly documented several mechanisms by which social support might be influencing health (Uchino et al., 1996).

Figure 1. A Dynamic, Functional, Multidimensional Model of Holistic Health
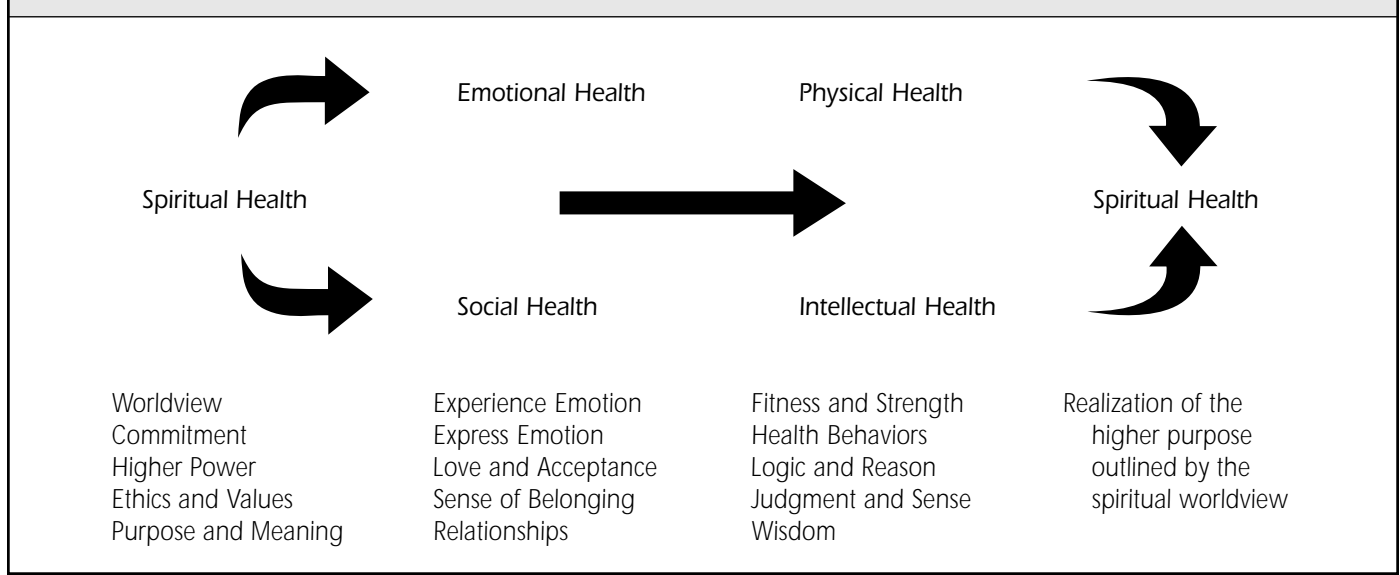
As a result the health care community is working diligently to incorporate social support into treatment protocols (Hurdle, 2001; Luskin et al., 1998). Based on more recent research efforts there is growing interest in incorporating spiritual support into patient care strategies (Castledine, 2003; Graber & Johnson, 2001; Kearns, 2002; Lemmer, 2002; Schweitzer, Norberg, & Larson, 2002). The same research and practice efforts that are taking place in patient care settings should also be taking place in health education and health promotion settings (Hawks et al., 1995).

A DYNAMIC, MULTIDIMENSIONAL, FUNCTIONAL MODEL FOR HOLISTIC HEALTH

One step toward the harmonization of practice and theory in health education is the refinement of theories and models that represent a dynamic, multidimensional, functional characterization of health, and that can guide future approaches to health education. As previously suggested in the literature, the linchpin in such a philosophical model may be spiritual health (Meeks, 1977; Waite et al., 1999; Young, 1984). As defined by one author, spiritual health involves high levels of commitment to a well-defined worldview (Hawks, 1994). The worldview provides personal clarity in un-

derstanding the purpose of life and one's place in it. The worldview further offers a value system and an ethical path for fulfilling the higher purpose that life affords. The importance of relationships, the nature of a higher power or larger reality, and a sense of personal worth are also encompassed within the spiritual worldview. Even in modern secular societies it may be the strength of the spiritual worldview that provides grounding, direction, personal peace, coping skills, and the hope of fulfillment (Brown, 2003).

In a dynamic functional model of holistic health (Figure 1), spiritual health represents purpose and higher meaning in life along with the value system that defines proper actions and the nature of relationships. As such, good spiritual health fulfills foundational needs and provides the impetus for achieving positive emotional and social health. Emotional health is generally defined as the ability to experience and express the full range of human emotions in appropriate ways, whereas social health involves the quality of our relationships, satisfaction in our social roles, our sense of belonging, and feelings of love and acceptance (Hawks, 1994). As shown in the model, and as demonstrated in the literature, high levels of spiritual, emotional, and social health can positively impact physical

and intellectual health outcomes, including a heightened enthusiasm for practicing positive health behaviors—the real goal of health education (Hammermeister & Peterson, 2001; Uchino et al., 1996; Waite et al., 1999; Williams et al., 1999). To the degree attained, physical and intellectual health become the tools for realizing the higher purpose that is encompassed within the spiritual worldview and the cycle continues. Once inspired by the possibility of spiritual fulfillment, the couch-bound gentleman described previously may be more eager to consult with the health educator as to the best methods for giving up addictive substances, increasing exercise, and managing his diet.

For the limited instances in which such a comprehensive approach has been taken, mostly in the medical field, the level of success has been exceptional. By including program strategies that target spiritual and emotional development as the prerequisites to health behavior change, atherosclerosis has been reversed (Ornish et al., 1998), and medically unmanageable pain has been mitigated (Kabat-Zinn, Lipworth, & Burney, 1985). The implications for illness prevention and health education are intriguing, but remain largely unexplored (Hawks et al., 1995).

As dictated by our modern definition of

health, this model is truly multidimensional, dynamic, and functional. But implementation of this paradigm will be far more challenging than the current strategy of focusing on new strategies to creatively dispense physical health information to an unmotivated population. Although inexpensive, at least in comparison with medical treatments, the multidimensional approaches alluded to in the previous paragraph are nevertheless very time- and energy-intensive. Programs last many weeks, or even months, and the level of involvement for both educators and participants is high. Although a single dose of a small pill might be preferred by the client, an intensive, comprehensive approach that addresses all dimensions of health is capable of providing lasting, life-altering solutions that can be achieved in no other way (Kabat-Zinn et al., 1985; Ornish et al., 1998).

The growing levels of alienation, apathy, and unhealthy lifestyles that are apparent in many modern societies are perhaps a reflection of diminished spiritual and emotional well-being (Cowley, 2002). It thus behooves health educators to better understand the dynamic and influential nature of spiritual health (an acknowledged yet largely ambiguous dimension in our definition of health) and devise appropriate ways to promote it along with social, intellectual, and emotional health.

CONCLUSION

The profession of health education, if so inclined, is in a position to more fully encourage and support a holistic health and wellness transition in the populations it serves. This requires efforts at both the individual and the national level. First, there must be a push within the profession to clearly define and operationalize concepts associated with the various dimensions of health. Second, there must be an effort to incorporate nonphysical outcomes into national and local health objectives. This must also include national and local resource allocation mechanisms that encourage health education researchers to design, implement, and evaluate programs that target the full

spectrum of health dimensions. Finally, it requires that as individual researchers and practitioners we become better versed in the various dimensions of health by conducting appropriate program design, implementation, and evaluation agendas that further refine models and theories and guide more effective practices. Along the way we must be willing to run contrary to popular notions against meddling with such things as spirituality and step into uncharted territory in terms of the knowledge and educational strategies that must become the new tools of health education (Hawks et al., 1995).

Other helping professions, including medicine, nursing, social work, psychology, and health counseling are already incorporating spiritual, emotional, and social protocols into their treatments, practices, and professional preparation programs (Dudley & Helfgott, 1990; Gelo, 1995; Kearns, 2002; Matthews et al., 1998; Tart & Deikman, 1991). Commitment to such a course by the profession of health education will perhaps represent the beginnings of a process that will allow us to become a leader in promoting the type of health in which we profess to believe, and thereby enable us to realize more effectively the ultimate goals of health education. Each step up the stairway that leads to the realization of health education objectives will gradually become a sure one.

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