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RESTORING THE 'BODYMIND' TO WELLNESS

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Restoring the ‘Bodymind’ to Wellness

Synopsis:

The traditional biomedical paradigm of healthcare and wellness in the United States today is not holistically serving our society’s 21st century healthcare needs. This outdated paradigm is either directly causing or significantly contributing to our problems with healthcare in the United States today (Granello, 2013). What is needed is a paradigm shift in how balance, health, and wellness are truly defined and achieved by including and acknowledging all aspects of the body, mind, spirit, and emotions into one, ‘bodymind’ (Sova, 2003). The use of Complimentary Alternative Medicine (CAM) therapies are explored, especially that of Ai Chi, an aquatic water exercise and relaxation program. Results from a research study focusing on what types of stress counselors face, self-assess, and manage reveal their use of coping strategies and techniques they utilize.

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Abstract

The traditional biomedical paradigm of healthcare and wellness in the United States today is not holistically serving our society's 21st century healthcare needs. This outdated paradigm is either directly causing or significantly contributing to our problems with healthcare in the United States today (Granello, 2013). What is needed is a paradigm shift in how balance, health, and wellness are truly defined and achieved by including and acknowledging all aspects of the body, mind, spirit, and emotions into one, 'bodymind' (Sova, 2003). The use of Complimentary Alternative Medicine (CAM) therapies are explored, especially that of Ai Chi, an aquatic water exercise and relaxation program. Results from a research study focusing on what types of stress counselors face, self-assess, and manage reveal their use of coping strategies and techniques they utilize.

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Historical Perspectives

A tremendous paradigm shift is needed in the way Americans perceive wellness and the term, healthy. Things need to change, including philosophies, mindsets, hallowed traditionally-held belief systems, and outdated strategies. “The problem simply put is that our traditional biomedical paradigm of healthcare is grossly mismatched for our American society’s 21st century healthcare needs. It is this basic mismatch between our present day needs and the dominant traditional biomedical paradigm that is either directly causing or significantly contributing to our problems with healthcare in the United States today” (Granello, 2013, p. 2). In the 1900s, our traditional biomedical model of healthcare had a focus on finding underlying pathogens that cause infectious disease. Back then, the average lifespan was 49 years, and most people died of infectious diseases like influenza and tuberculosis. This approach was needed then and served its purpose well.

Fast forward to the 21st century, with the average lifespan of 77.7 years, and it is now a vastly different story. “People in the United States are not dying of infection-related diseases, but instead of chronic lifestyle-related diseases” (Granello, 2013, p.3). The U.S. Department of Health and Human Services, Centers for Disease Control and Prevention reported that at least half of the premature deaths in the United States are caused by lifestyle and behavior factors (Centers for Disease Control and Prevention [CDC], 2008, as cited in Granello, 2013, p. 3). What we really need is education and assistance regarding avoiding and managing chronic illnesses, yet our healthcare systems are still focused on the treatment of sickness and

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dysfunction. We spend an inordinate amount of time and money in remedying problems, instead of preventing their occurrence in the first place.

Forty-five percent of Americans suffer from at least one chronic disease, such as heart disease, diabetes, pulmonary disease, and cancer (which are higher than in any other country), and are among the most costly and preventable diseases in the U.S. The five most costly diseases are: heart disease, trauma-related disorders, cancer, asthma, and mental disorders. The largest increase in expenditures from 1996 to 2006 was for mental disorders, which rose from \$35.2 billion in 1996 to \$57.5 billion in 2006 (Granello, 2013, p. 4). Noted physician, Dr. Andrew Weil, summed up the current healthcare philosophy by stating, "We do not have a healthcare system, we have a disease management system" (As cited in Granello, p. 4).

But, what are we doing wrong? We have one of the strongest, most advanced healthcare systems in the world. What have we bypassed and left out? For centuries, Eastern medicine has focused on the holistic paradigm of wellness, in preventing illness, and looking at the entire person as a system and unique entity with interwoven parts. "The World Health Organization as early as 1947 defined health as being more than the absence of disease, and in 1964 emphasized the well-being aspect with its definition of health as 'a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity'" (World Health Organization [WHO], 1964, p. 1, as cited in Granello, 2013, p. 8). It seems that Western philosophies have severely lagged behind the times in keeping separate the wellness of the body and that of the wellness of the mind.

Western philosophical and clinical theoretical ideas have dealt with healing the mind since before the time of Freud, Adler, and Jung. It has been accepted practice for most of the twentieth century that counselors, therapists, psychiatrists, analysts, psychologists, and social

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workers help to heal one's mind, while physicians, doctors, and advanced practical nurses heal one's body. "The traditional medical model has a pathogenic, reductionist, and disease focus, while in contrast the wellness model has a salutogenic (health enhancing) focus that is related to constant striving for optimal functioning (Granello, 1995, as cited in Granello, 2013, p. 8). It is only in recent years that theorists have accepted the notion of a mind-body connection, or as is often referred to now as one word: 'bodymind.' "Bodymind work, mindfulness, contemplation...whatever you call it, is true integration...Optimal health, then, is the integration and harmony of mind, body, spirit, and emotions. Yet for many health professionals, virtually all attention is being placed on the physical well-being because it is the most tangible aspect of health" (Sova, 2003, p. 19).

The Rise of Complimentary Alternative Medicine Therapies

The National Center for Complementary and Alternative Medicine (NCCAM) is part of the National Institutes of Health. A large part of NCCAM's mission is to organize and define the world of Complementary and Alternative Medicine (CAM). Thirty-four percent of people surveyed (Eisenberg and associates, 1993) stated they had used at least one unconventional therapy in the last year for such chronic conditions as back pain, insomnia, and headaches. The most commonly cited CAM therapies listed in order from most to least utilized are: natural products, deep breathing, meditation, chiropractic and osteopathic treatments, massage, yoga, diet-based therapies, progressive relaxation, guided imagery, and homeopathic treatment. In addition, NCCAM classifies CAM therapies into the following categories: Biologically Based Practices, Energy Medicine, Manipulative and Body-Based Practices, Mind-Body Medicine, and Whole Medical Systems (Granello, 2013, pp. 60-63).

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Some of the most popular types of CAM therapies also include the use of: acupuncture, biofeedback, chiropractic manipulation, deep breathing, energy healing therapy, guided imagery, hypnosis, massage, meditation, naturopathy, Pilates, progressive relaxation, Qi Gong, Reiki, Tai Chi, and yoga (myriad of types) (Granello, 2013, pp. 64-66). This list is by no means exhaustive; it simply demonstrates the growing realization that CAM therapies are frequently being utilized and accepted by increasing numbers of people.

Of particular interest for this paper are the use of Chi, which is a kind of in-vivo energy or life force (essence and breath), and the understanding of energy meridians, which are pathways that allow the Chi to flow through the body. This follows the concept of two forces that oppose, but also complement the other in the classical Tai Chi figure of Yin and Yang. Practitioners believe it is necessary to have both components of Chi. "One would not be able to perceive white if there is no black, and vice versa. Further, there is no complete or pure force of white or black, there is always some black in white or white in black...health is determined by the relative balance between opposing forces rather than an absolute status" (Granello, 2013, p. 67). An in-balance in your Chi, therefore, can indicate a disease process in the making that warrants further investigation.

Laughter Yoga and Ai Chi

Two types of CAM therapies this author has been quite involved with over the past three and one-half years are Laughter Yoga and Ai Chi. Laughter Yoga was created by Dr. Madan Kataria in 1995 in Mumbai, India. A physician by trade, Kataria was greatly impressed by literature he had read involving the powerful healing use of laughter in helping persons deal with chronic pain and debilitating illness. The concept is quite simple, but can have quite meaningful

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results. You combine yogic, or pranayama, deep breathing techniques with special guided exercises to initially simulate laughter in a group setting. Very quickly, the laughter becomes spontaneous and genuine, and the health benefits can be profound. Laughter Yoga is currently being researched as a very promising CAM-type technique to utilize for counselor and client wellness. Some of the health benefits being researched are: the reduction of blood pressure, stress relief, yogic workout (good for your heart, diaphragm, abdominal, intercostal, respiratory, and facial muscles), and the increase of endorphin production, giving you a sense of well-being (Retrieved from <http://laughteryoga.org>).

Ai Chi, created in Japan in the 1990s by Jun Konno, a Japanese authority on aquatic fitness, combines the Tai Chi concepts of Shiatsu, Watsu, and Qi Gong techniques. It is conducted while standing in a warm-water pool of 88-92 degrees Fahrenheit (ideally), in shoulder-depth water using a combination of deep breathing, and slow, broad movements of the arms, legs, and torso. The practitioner sinks down into the water and obtains the Ai Chi stance to complete the 19 movements, over roughly a 45 minute period. As Konno describes, "Ai Chi is a water movement and relaxation program that has been created to help aquatic practitioners and clients enjoy the water in a flowing, yet powerful progression. It is an efficient exercise program that increases oxygen and caloric consumption simply with correct form and positioning in the water...creating improved range of motion, balance, and mobility" (Retrieved from www.ruthsova.com/aichiart2.htm, para. 1). This also promising CAM-type therapy is being utilized by thousands of aquatic practitioners and healthcare workers worldwide, and has been involved in numerous on-going studies for its efficacy and promising wellness outcomes.

Ai translated means "love," and *Chi* means "your breath/essence/being." Therefore, Ai Chi interprets as, "love your essence." Accepting one's essence, being, life-force, or breath, as is,

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right now, is a central tenet of the Ai Chi philosophy. In addition, restoring the 'bodymind' and being flexible and pliant in obtaining balance creates harmony within each person's Chi.

A common Japanese proverb states: "Willow does not break under weight of snow" (as cited in Sova, 1999, p. 16). The implied meaning is that stiff branches, bones, and inflexible psyches may break: however, pliant bones, connective tissues, and psyches will not. Ai Chi helps one to achieve pliancy. It is said that roundness, continuity, and softness are all a part of life, which don't inherently cause strain. The Japanese believe that if you don't go against nature, you will last long. Ai Chi moves with nature, and its circular, continual movements create an external feeling of harmony that with repetition, become internal (Sova, 1999).

Participants of Ai Chi gain an overall understanding of the concepts, philosophy, and proper yogic/diaphragmatic breathing techniques associated with restoring the 'bodymind.' This enhances relaxation, calmness, and peace. When the body experiences stress, its ancient programmed response is to rev up the autonomic sympathetic response by excreting the stress hormones of norepinephrine, adrenaline, ephedrine, and cortisol. They are the body's "flight or fight" response, required in extreme danger or when under considerable stress, signaling the body to prepare itself for what lies ahead. However, in our over-stressed, anxiety-driven world, the body is often thrown into this type of reaction far too often, which over time becomes toxic to the 'bodymind' and spirit. The 'bodymind' seeks to enhance the parasympathetic system of the body to restore it to homeostasis and balance. Incorporating the correct diaphragmatic breathing techniques, combined with the slow, soft movements of Ai Chi can restore the being to its full potential. Ai Chi helps to strengthen one's core, while also building endurance and increasing oxygenation, and is especially helpful for those with mobility issues, joint discomfort, and who are highly stressed (Sova, (1999)).

Exploring How Other Counselors De-Stress

Professional Quality of Life and Wellness Study

Being a counselor by trade, the author of this paper wanted to especially investigate how other counselors de-stress in an effort to more fully understand the types of wellness and self-care strategies that counselors utilize, as well as coping techniques employed. Therefore, this author conducted a mixed-methods study of rural school counselors in 2013 in the Midwest region of the United States through Northern State University. After obtaining appropriate Institutional Review Board permission to conduct the study, the established research questionnaire, the *Professional Quality of Life Scale (ProQOL), Version 5*, developed by Stamm, 2009-2012, was utilized, along with eight qualitative survey questions developed (and previewed) by this author. The school counselor population was chosen in particular because in the rural Midwest, many school counselors have to work in more than one school at a time, are often the only school counselor in the building, are frequently further than 50 miles away from another school counselor for collegial support, and are bound by confidentiality regulations which prohibit the sharing of student sessions.

The surveys were disseminated between February to June, 2013 through the use of the snowball sampling method. Surveys were conducted via online and in-person. In all, 186 surveys were disseminated, with a return rate of 55 ($n = 55$), making it close to 30% (.295698). The first four questions had to do with demographics. Question one asked their age; the range was age 24 – 63. Question two asked their gender; there were 41 females and 14 males who participated in the study. Question three asked how long they had been school counselors; the range was less than one year – 28 years. Question four asked their ethnicity, with 52 answering Caucasian (or White), 2 answering Native American, and 1 person declined to answer. The responses for

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question three varied: "Do you practice wellness and self-care strategies? If so, what type and how often?" The vast majority of respondents (52 out of 55) stated they did at least some times, with only 3 respondents stating they did not do anything. The most common responses centered around some sort of exercising (35 out of 55) with the most typical being: walking, working out, running, playing sports, using yoga/Pilates, or lifting weights. Several respondents stated they also used deep breathing exercises, meditation, reading, praying, taking trips, eating healthy, joining a Bible study/devotional group, sharing with colleagues, visiting with family/friends, and watching television.

Question six asked: "What types of activities cause you the greatest distress on your job as a school counselor?" Again, the answers varied quite a bit with only one participant stating, "nothing." Some of the representative responses were: "A school counselor's undefined role and being given extra responsibilities causes me stress." "I get frustrated with adults who seem disinterested in their students." "When there is a suicidal plan or attempt made." "Not enough time and balancing mutual roles." "Personality disorders and politics." "Children with home challenges and self-harm issues." "Sometimes I feel that others are unaware of what we do as school counselors." "Irate parents, testing, suicide interventions, deaths of students and staff, crabby teachers." "Non-school counseling duties." "Administrative work and testing." "Dealing with severe cases – suicidal or depressed students." "The system! Roadblocks in trying to help kids." "Parents' abuse and neglect of their children." "Situations that are out of my students' control because of their age." "Letting people down. Testing." "Adults – who want more than I am able to give them, or do for them." "Children who I know have no home life and get no encouragement from that area." "Deciding if parents are abusing their children and calling the Department of Social Services, and fearing the parents will abuse them more after they have

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been investigated.” “Working with an illogical and inconsistent set of rules.” “When I hear of kids being abused and abusing substances.” “Test coordinating, uncooperative parents, and non-professionalism.” “The lack of time I have available to meet with students in addition to the requirements that are administrative.” “Suicide, student deaths, ‘other duties as assigned,’ and parents not being parents!” “Being spread too thin. There is one of me and 280 kids.” “Circuit overload, lack of understanding by staff, clerical and multiple duties.” Lastly: “Having to wear so many different hats every day, and that people ‘expect’ this from you. Some days make you think whether or not what we do is worth it.” The central themes from the above focus on dealing with the challenges of suicidal, depressed, and abused children, a system that is less than perfect, having too many varied tasks and being spread way too thin, being assigned too many administrative duties (including test coordination), and being felt taken advantage of due to unrealistic expectations and lack of understanding of the school counselor’s role.

Question seven asked, “What helps you most to de-stress?” Many of the common responses focused on the use of exercise (including CAM therapies), meditation, prayer, talking to professional colleagues, spending time with family and friends, doing hobbies, using the drive home to decompress, and time alone. The last question, number eight, asked, “What kinds of support systems do you have and utilize?” The central themes in responses for this question were: professional colleagues, family, friends, church, supervisors, co-workers, spouses/partners, children/grandchildren, consultation with other colleagues, and religious leaders (listed in no particular order).

There are 30, Likert-scaled questions on the *Professional Quality of Life Scale (ProQOL) Version 5* (Stamm, 2009-2012) questionnaire. Participants of this study were also given the *ProQOL 5* to fill out. The Likert choices were: 1=Never; 2=Rarely; 3=Sometimes; 4=Often; and

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5=Very Often. The scoring guide in the manual produced three subcategories of levels:

Compassion Satisfaction, Burnout, and Secondary Traumatic Stress. Compassion Satisfaction had to do with the pleasure you derive from being able to do your work well. The average score is 50 (SD=10, alpha scale reliability .88). About 25% of people score higher than 57 and about 25% of people score below 43. If a person scores in the higher range, they probably derive a good deal of professional satisfaction from their position. Burnout is one of the elements of Compassion Fatigue, and is associated with feelings of hopelessness and difficulties in dealing with work. The average score is 50 (SD=10, alpha scale reliability .75). About 25% of people score above 57, and about 25% score below 43. If the score is below 43, this probably reflects positive feelings about the person's efficacy to be effective in their work. A second component of Compassion Fatigue is considered the Secondary Traumatic Stress scale. It is about work-related secondary exposure to extremely or traumatically stressful events. The average score for this is also 50 (SD=10, alpha scale reliability .81). About 25% of respondents score below 43, and about 25% score above 57. If the participant's score is above 57, that person may want to consider what it is at work that may be frightening, or examine how he/she feels about the work environment (Stamm, 2009-2012).

For this author, having worked as a school counselor and director of four programs for over 14 years, the above *qualitative* responses were not surprising. The rigors and demands of the school counseling profession can be intense and overwhelming on many occasions. The candor and openness of the responses were revealing, however, and acknowledged the challenges and frustrations that school counselors endure on a daily basis, often with no professional colleagues to consult with in the same building. Based on these responses, as well as

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personal observations over 14 years as a school counselor, it was significant to realize the majority of school counselors were utilizing some sort of self-care and wellness strategies.

“Responding to the needs of traumatized individuals can take its toll on the psyche of mental health professionals... Figley (1995) defines the normative occupational hazard of working with traumatized clients as compassion fatigue, derived from empathic contact with traumatized clients and listening to their traumatic experiences” (Dass-Brailsford, 2010, p. 213). Based on the qualitative responses from the respondents in this study, a reasonable hypothesis for the *ProQOL 5* (Stamm, 2009-2012) survey results would be that participants should score low on the “Compassion Satisfaction Scale,” and high on the “Burnout Scale” and the “Secondary Traumatic Stress Scale.” However, in analyzing the data, quite the opposite was found. For the Compassion Satisfaction Scale, 28 out of 55 (51%) scored in the “average” range, with 27 out of 55 (49%) scoring in the “high” range. It would seem that at least 25% would score in the normed predicted “low” range due to possible resultant feelings of having less compassion than before, or it being diminished over time. The same dynamics were found with the Burnout Scale, with 39 out of 55 (71%) scoring in the “low” category, and 16 out of 55 (29%) scoring in the “average.” One would assume, again, based on the many responses, that the scores might hover more in the average-high range. Lastly, the same evidence was found with the responses to the Secondary Traumatic Stress Scale, with 40 out of the 55 respondents (73%) scoring in the “low” range, and 15 out of the 55 (27%) scoring in the “average” range. When compared with age, gender, length of time as a school counselor, or ethnicity, none of these factors seemed to affect how a person scored.

Conclusions, Summary, and Questions for Further Inquiry

The results of this study revealed some surprising outcomes. The written qualitative responses shared by the participants demonstrated that most take part in some sort of self-care, and many use traditional, as well as CAM therapies to help reduce their stress levels and increase their coping mechanisms. Almost all the participants shared that their jobs can be very challenging at times, and they often felt unsupported or under-valued. However, being counselors, it seemed the majority took their own advice, knew when to reach out to colleagues, family, friends, their faith, or all the above, and they took action when it was needed in order to maintain a healthy perspective towards their work and environment.

The quantitative results of the *ProQOL 5* (Stamm, 2009-2012) were significant in that the vast majority of the respondents did not fall into the expected normed ranges. The *ProQOL 5* questionnaire was developed to be utilized with various types of helping professions. The participants in this study took their surveys by themselves without others' input. Surprisingly, not one participant scored in the normed anticipated "low" range for Compassion Satisfaction, the normed anticipated "high" range for Burnout, or the anticipated "high" range for Secondary Traumatic Stress. Perhaps the training that school counselors receive and knowledge of the type of environment they will be working in, often the only person on staff with that designation, prepares them to utilize ancillary coping mechanisms in order to continue to feel satisfied, competent, and empathic. In addition, school counselors know the value of venting in a safe environment and discussing one's concerns in a productive way in order to feel empowered to move ahead in a healthy manner. The mere activity of being able to write about what is frustrating and distressing in one's job may have been cathartic in its own right during this

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survey. The overall satisfaction of the profession of school counseling reported by the participants was not diminished, even though it clearly had its stated difficulties and challenges.

These are only some possible conclusions drawn from the data analysis of this survey study, and anecdotal experiences of the author. Clearly, further research in the area of utilizing CAM therapeutic methodologies needs to be explored as all counselors continue to do the vital work that they do. Some questions to ponder in relation to this study are: Does suggesting the use of CAM-type therapies have a place in traditional Western philosophical and clinical therapeutic modalities for clients, especially those dealing with trauma? What kinds of research need to be conducted to more fully understand the holistic nature of the 'bodymind?' Finally: With more evidence-based research, will counselors be able to incorporate Eastern philosophical paradigm shifts with Western theoretical mindsets for their own wellness, and that of their clients?

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