WHOLISTIC HEALTH PROGRAM FACILITATORS GUIDE

This guide outlines the evidence, data, and references for the Wholistic Health Program and is designed for trained facilitators.

Contents

INTRODUCTION

Overview

The Wholistic Health Program © is designed to improve physical, mental, and optionally spiritual health by addressing a core influence in our lives: relationships. Research shows that there are several factors that impact health, from trauma, to coping mechanisms, to outlook on life and each is significantly influenced by the quality of our relationships. Therapies and techniques used in the program include cognitive behavior theory, neuroplasticity cognitive training, stages of change, and behavior redirection.

The World Health Organization (WHO, 2012) assessed countries around the world and determined that physical health, mental health, social relationships, environment, and spiritual health are factors that contribute to quality of life. The Wholistic Health Program © also identifies these factors using 10 guided exercises that address trauma, boundaries, positive self-talk, gratefulness, inner circles and friendships, detoxing our environment, emotional intelligence, overcoming fear, forgiveness, identity, and more. The workbook is designed to be completed in 21 days and is flexible whether self-directed or assisted through a clinical professional.

A significant gap exists between what research shows can improve health and what is provided to individuals, families, communities, and organizations in the field (Atkins et al. 2016). The Wholistic Health Program © is a successive program that brings research into practice with evidence of positive outcomes.

Evidence-Based

The Wholistic Health Program © has a complimentary Wholistic Health Assessment © that can be utilized in the beginning, at the end, and optionally in the middle of the program to determine successful progression. This program, as well as the assessment, was derived through rigorous research methods and the outcomes of their application have been critically assessed. The assessment is validated and reliable with an overall Cronbach alpha score of 89%. More information can be found in the Wholistic Health Assessment © Manual.

Benefit

The brain was thought to be "fixed" but growing research shows the brain changes, can continue growing, and the brain's structure can improve. This program uses cognitive behavior therapy and behavior redirection techniques, specifically repetition, to build neural pathways for habits that encourage healthy relationships, improved health, and an increased quality of life. It shows evidence of positive outcomes by:

- Detoxing physically and mentally.
- Replacing unhealthy habits with positive habits.
- Increasing emotional intelligence.
- Practicing positive self-talk.
- Setting healthy boundaries with important people.
- Addressing and processing traumatic experiences.
- Reshaping the external environment.
- Reshaping inner circles.
- Addressing forgiveness.
- Overcoming fear.
- And many more factors scientifically found to impact relationships, health, and quality of life.

An Inspiring Story About Wholistic Health: Saved by a Vegan Prison

In 1997 Maranatha Private Corrections LLC won a bid for the Victor Valley Medium Community Correctional Facility in Adelanto, California. The owner, Terry Mooreland, decided to offer an optional program in the 500-inmate prison. Prisoners could decide to stay on one side of the prison and continue as usual, with no change in food and activities or they could go to the other side of the prison and participate in a NEWSTART program that included bible studies, job training, and anger management and eat a vegan diet. During this study, the State of California had a recidivism rate of 95% while this facility had a recidivism rate of 2%.

In 1999, Eric Vandennoort was living a life that most of us only read about or see on television. He was homeless and his life was one of substance abuse, petty crimes and run-ins with the law. In fact, his rap sheet became so long that a California judge finally got fed up and threw him into prison instead of the county jail. This judge had no idea that his decision would change Eric's life forever. Like most inmates, Eric was moved around within the California prison system and landed at

the Victor Valley Medium Community Correctional Facility. A change of diet and lifestyle were nowhere on his mind, so, when Eric was asked whether he wanted to live on the vegan side or the side that offered the regular California Corrections programs, his only concern was whether the vegan side offered tobacco. He had heard that the vegan wing offered better treatment so he figured "as long as I have my tobacco, how bad can a vegan diet really be".

Eric landed a job in the kitchen working for Julianne Aranda, the nutrition coordinator. As he went through the structured program offered on the "vegan side", he found himself learning not only from Julianne, but from all the nutrition classes that were offered. Eric also took Bible studies being given by the Seventh-day Adventist Church. "The Adventist church was experimenting with a wholistic approach to addictions", recalls Eric. "They had a program called NEW START where every letter stood for something". The NEW START acronym stands for Nutrition, Exercise, Water, Sunlight, Temperance, Air, Rest and Trust in God.

Over a six-month period, Eric would see his life change completely. The wholistic approach to rehabilitation that included both a vegan diet and spiritual training had a deep and lasting impact on his life. He began reading good books, he quit smoking and his entire attitude toward life took a positive spin. "The facility was a breath of fresh air", said Eric. On July 11, 1999 Eric Vandennoort walked out of the Victor Valley facility a new man. "From the day I left, I have never used drugs again or taken another drink". In fact, today, he is happily married and is working as a licensed drug and alcohol counselor in New Port Beach, California. "They broke a chain for me with diet and spiritual intervention", says Eric. "I owe it all to them. I no longer have to push a cart around on the streets."

PROGRAM FACILITATION

Program Schedule

The program is designed for flexibility based on individual needs and time, however, in a professional or group setting, it's recommended that participants follow the schedule listed below. The schedule supports completion in three weeks, which is conducive to most residential programs and current billing authorizations. It is anticipated that someone may need additional time to fully transform a learned habit.

Session 1	Overview
Session 2	Assessment*, Exercise 1, 2, 3
Session 3	Exercise 4, 5, 6, 7
Session 4	Exercise 8, 9, 10, Assessment*

*The assessment is completed 1-24 hours before the program and 1-24 hours after completion.

Processing Exercises

It is recommended that participants have at least one session each week to process the completed exercises *after* the participant has completed them. The facilitator should not complete the exercises with the participant(s) as this could lead to inadvertently projecting thoughts or feelings that may not be wholly related to the participant.

WATCH THE VIDEO ON FACILTATING THE WHOLISTIC HEALTH PROGRAM ©

Session One – Overview

1. Introduction of Facilitator(s) – Share at least your name and title.
2. Welcome and Warm Up – Choose a question to ask the participants to help them warm up to each other. Ask them to share their name first and answer the question yourself as well.
3. Introduction of Program – Play Overview video or recommend participants watch it.
4. Program Expectations – Length of program, meeting days / times, respect each other, confidentiality, etc.
5. Location Expectations – Restroom locations, cell phones, breaks, etc. as applicable.

6. Program Discussion Option 1 – Participants should complete Exercise 1 as soon as possible, so it may be easier for them to complete this together during this session. Read Exercise 1, allowing participants to volunteer taking turns. Give them personal time (approximately 5 – 10 minutes) to complete the exercise in their book. You may play soft instrumental music during this time.

7. Program Reminder – Remind participants to complete / finish the Wholistic Health Assessment © and exercises 1 – 3.

8. Program Resources – Send participants the program schedule, links to the recorded videos, and the 988 mental health hotline.

Session Two – Exercises 1-3

1. Welcome and Warm Up – Choose a question to ask the participants to help them warm up to each other. Ask them to share their name first and answer the question yourself as well.

2. Program Expectations – Briefly cover the program expectations, respect each other, confidentiality, etc.

3. Program Exercises – Remind participants of the titles of each exercise they completed:

   - Exercise 1:   Physical Health: Importance of Detoxing
                      Spiritual Health: Why and How to Fast
   - Exercise 2:   Mental Health: Addressing Unhealthy Habits
                      Spiritual Health: How Forgiveness Unlocks Health
   - Exercise 3:   Mental Health: Forming New Healthy Habits
                      Spiritual Health: Establishing Identity and Purpose

4. Program Discussion Option 1 – Ask participants to share a habit they plan to work on during the program.

5. Program Discussion Option 2 – Ask participants to share their choices for their detox and/or fast.

6. Exercise Review – Ask participants if there's an exercise that stood out to them or helped them and why. Encourage them to press forward.

7. Program Reminder – Remind participants that their next exercises are 4 – 7.

Session Three – Exercises 4-7

1. Welcome and Warm Up – Choose a question to ask the participants to help them warm up to each other. Ask them to share their name first and answer the question yourself as well.
2. Program Expectations – Briefly cover the program expectations, respect each other, confidentiality, etc.
3. Program Exercises – Remind participants of the titles of each exercise they completed:

   - Exercise 4:   Mental Health: Understanding and Addressing Trauma
                     Spiritual Health: Healing Spiritual Trauma
   - Exercise 5:   Mental Health: Emotional Regulation
                     Spiritual Health: Identifying the Enemy
   - Exercise 6:   Mental Health: Power in Positive Thinking
                     Spiritual Health: Overcoming the Spirit of Fear
   - Exercise 7:   Mental Health: How Words Shape Your Future
                     Spiritual Health: The Power of Words

4. Program Discussion Option 1 – Ask participants to think about a recent experience and write down the granular emotion they felt during that experience on a small piece of paper. Ask a few or all participants to take turns sharing their experience. Ask the rest of the group to guess their granular emotion. After the discussion, ask the group what they learned from guessing others' granular emotion. It's common for people to guess an incorrect granular emotion. Oftentimes we can make inaccurate assumptions which can lead to misunderstandings and arguments. Having clarity can help us understand each other better and resolve conflicts more peacefully.
5. Program Discussion Option 2 – Ask participants to take 10 minutes to write a letter of gratitude to someone that made a positive impact in their life. Ask participants to take turns reading the letter of gratitude out loud and encourage participants to read or send the letter to the person they wrote about.
6. Exercise Review – Ask participants if there's an exercise that stood out to them or helped them and why. Ask the participants how their detox and/or fast is going. Encourage them to press forward.
7. Program Reminder – Remind participants that their next exercises are 8 – 10.

Session Four – Exercises 8-10

1. Welcome and Warm Up – [Choose a question](#) to ask the participants to help them warm up to each other. Ask them to share their name first and answer the question yourself as well.
2. Program Expectations – Briefly cover the program expectations, respect each other, confidentiality, etc.
3. Program Exercises – Remind participants of the titles of each exercise they completed:

   - [Exercise 8](#):   Mental Health: Establishing Healthy Boundaries
     Spiritual Health: Equipping for Spiritual Battles
   - [Exercise 9](#):   Mental Health: Shaping a Healthy Environment
     Spiritual Health: How to Guard Our Heart
   - [Exercise 10](#):   Mental Health: Choosing Our Inner Circle
     Spiritual Health: Detaching Negative Relationships

4. Program Discussion Option 1 – Ask participants to discuss what they believe their character strengths are and which characteristics they want to work on and why.
5. Program Discussion Option 2 – Ask participants to share one or two movie or music recommendations that they believe are positive or uplifting. This helps everyone extend their options.
6. Program Discussion Option 3 – Ask participants to share the changes they're making to their environment and inner circle. Ask participants how they are deciding who will be their push, pull, and pour relationships.
7. Exercise Review – Ask participants if there's an exercise that stood out to them or helped them and why. Ask the participants how their detox and/or fast is going. Encourage them to finish strong.
8. Program Reminder – Remind participants to complete the Wholistic Health Assessment ©.
9. Program Resources – Send participants a congratulations email, a certificate of completion (if applicable), and the link to the Wholistic Health Assessment ©. Consider a congratulations meal, potluck, or starting an online or phone group for this cohort so they can stay connected.

Exercise Overviews

Exercise 1 | Detox and Fast

Review principles for naturally detoxing the blood and set a solid foundation for why and how to fast during the Wholistic Health Program ©.

Exercise 2 | Addressing Unhealthy Habits

Identify and address unhealthy habits and review how forgiveness (of ourselves and others) unlocks health.

Exercise 3 | Forming New Healthy Habits

Choose and begin strengthening healthy habits while documenting your vision for your life and establishing your identity and purpose.

Exercise 4 | Understanding and Addressing Trauma

Identify and address traumatic experiences in a healthy way and start the process of breaking spiritual trauma and oppression.

Exercise 5 | Emotional Regulation

Practice using granular emotions to express thoughts and feelings and learn how negative spiritual forces use emotions and how you can regain control.

Exercise 6 | Power in Positive Thinking

Identify unhealthy thinking patterns and begin correcting destructive thoughts, including overcoming fear.

Exercise 7 | How Words Shape Your Future

See practical ways words shape our life and how to use words to reshape our future and our identity.

Exercise 8 | Establishing Healthy Boundaries

Practice setting healthy boundaries and clear expectations and how to use spiritual weapons with challenging people in our life.

Exercise 9 | Shaping a Healthy Environment

Start detoxing our environment, including our home and choices of entertainment and learn how to continually guard our heart and mind.

Exercise 10 | Choosing Our Inner Circle

Reflect on our relationships, specifically our inner circle and prepare to carefully remove negative relationships in our life.

Example Weekly Email

[Greetings],

Congratulations on the progress you made so far with the Wholistic Health Program ©. This week's exercises are listed below with links to the online videos. Our next session is [date and time].

- [Exercise 8]():   Mental Health: Establishing Healthy Boundaries
  Spiritual Health: Equipping for Spiritual Battles
- [Exercise 9]():   Mental Health: Shaping a Healthy Environment
  Spiritual Health: How to Guard Our Heart
- [Exercise 10]():   Mental Health: Choosing Our Inner Circle
  Spiritual Health: Detaching Negative Relationships

Remember the Spiritual Health Component is optional, although best results are when the program is completed in whole. If you have questions, please email [email address].

Best health

[Signature]

Example Weekly Overviews

<u>Week 1</u>

In the first week of the Wholistic Health Program ©, we dive deep into the essence of wholistic health, setting our intentions and destination for the journey ahead. We kickstart our transformation with a comprehensive Wholistic Health Assessment © and embark on a powerful 21-day detox and fast.

Throughout this week, we engage in vital physical and mental health exercises, including:

- The Importance of Detoxing

- Addressing Unhealthy Habits

- Forming New Healthy Habits

For those seeking spiritual growth, we offer optional exercises including:

- Why and How to Fast

- How Forgiveness Unlocks Health

- Establishing Identity and Purpose

Join us as we lay the foundation for a healthier, more balanced life.

<u>Week 2</u>

In the second week of the Wholistic Health Program ©, we delve into transformative practices that empower us to process trauma in a healthy way, enhance our communication through emotional intelligence, and understand the profound impact of our thoughts and words on our lives.

This week, we engage in powerful physical and mental health exercises, including:

- Understanding and Addressing Trauma

- Emotional Regulation

- The Power of Positive Thinking

- How Words Shape Our Future

For those seeking spiritual growth, we offer optional exercises including:

- Healing Spiritual Trauma

- Identifying the Enemy

- Overcoming the Spirit of Fear

- The Power of Words

Join us as we continue our journey towards wholistic health and well-being.

Week 3

In the third week of the Wholistic Health Program ©, we dive into the essential practices of establishing healthy boundaries, creating a nurturing environment, and strategically building a supportive inner circle. We collaborate and share practical resources to implement these principles effectively while continuing our transformative 21-day detox.

This week's physical and mental health exercises include:

- Establishing Healthy Boundaries

- Shaping a Healthy Environment

- Choosing Our Inner Circle

For those seeking spiritual growth, we offer optional exercises such as:

- Equipping for Spiritual Battle

- How to Guard Our Heart

- Detaching Negative Relationships

At the end of the 21 days, we conclude the detox and fast, and reassess our progress with the Wholistic Health Assessment © to identify the next steps on our journey to wholistic well-being.

Example Program Overview

3 Weeks to Greater Health and Relationships (Evidence Based)

The Wholistic Health Program © combines the power of cognitive behavior therapy and behavior redirection techniques, with a focus on repetition, to forge new neural pathways. These pathways cultivate habits that foster healthy relationships, enhance overall health, and elevate quality of life.

The Wholistic Health Program © demonstrates consistent positive outcomes through:

- Physical and Mental Natural Detoxification

- Replacing Unhealthy Habits with Positive Ones

- Boosting Emotional Intelligence

- Practicing Positive Self-Talk

- Establishing Healthy Boundaries

- Addressing and Processing Trauma

- Transforming the External Environment

- Reforming Inner Circles

- Embracing Forgiveness

- Conquering Fear

- And many other scientifically proven factors that enhance relationships, health, and quality of life

Join us on this transformative journey to wholistic well-being.

Example Flyer

Avoiding Program "Drift"

The Wholistic Health Program © is evidence-based and was piloted and tested, showing positive results. For this reason, it is important that the program is facilitated as it was originally designed and tested to receive best results. For example, not skipping sections of the program unless the section is designed to be removed (e.g. spiritual health). To do so could result in less effective outcomes. Sections can and should be tailored to the participant (e.g. physical detox can include removing sweet foods for one participant and removing salty foods for another). This is not considered program drift. Regular training and consistent expectations are recommended to prevent program drift.

WHOLISTIC HEALTH PROGRAM © REGULATORY STATEMENT

ABOUT THE WHOLISTIC HEALTH PROGRAM ©

The Wholistic Health Program © utilizes 10 exercises designed to improve physical, mental, and optionally spiritual health by addressing a core influence in our lives: relationships. The program has varying completion timeframes, is easy to follow, interactive, and can be self-directed, group supported, or supported by a clinical professional to meet the flexible needs of the individual. It was designed to fill gaps observed between healthcare practices and regulatory and accreditation requirements. It's format addresses some of the top regulatory and accreditation issues including having individualized and personalized treatment plans, using evidence-based programs, and incorporating spiritual health into treatment which is optional based on individual beliefs.

BENEFITS OF THE WHOLISTIC HEALTH PROGRAM ©

The Wholistic Health Program shows evidence of positive outcomes by: 1) Detoxing physically and mentally, 2) Replacing unhealthy habits with positive habits, 3) Increasing emotional intelligence, 4) Practicing positive self-talk, 5) Setting healthy boundaries with important people, 6) Addressing and processing traumatic experiences, 7) Reshaping the external environment, 8) Reshaping inner circles, 9) Addressing forgiveness, 10) Overcoming fear, and many more factors scientifically found to impact relationships, health, and quality of life.

EVIDENCE BASED WHOLISTIC HEALTH PROGRAM ©

The Wholistic Health Program was designed with extensive literature review, pilot participants, and sound techniques and models: Neuroplasticity Cognitive Training techniques, Cognitive Behavior Therapy techniques, Repetitive Behavior Redirection techniques, and the Stages of Change Model. The overall objective identifies healthy concepts and barriers to healthy relationships, reinforces a healthy foundation through awareness, and uses repetition to build and strengthen neural pathways for habits that encourage healthy relationships, improved health, and an increased quality of life. The accompanying Wholistic Health Assessment © encourages data informed progress and decisions.

FACILITATOR COMPETENCIES

Facilitator competencies extend to anyone that facilitates the program and interacts with program participants, whether clinical, professional, or not including counselors, discharge planners, physicians, psychologists, nurses, pastors, health ministry leaders, etc.

Spiritual Competence

Facilitators should ensure spiritual competence for participants that choose to incorporate the spiritual health component. The Association for Spiritual, Ethical and Religious Values in Counseling (ASERVIC) has fourteen spiritual competencies that are endorsed by the American Counseling Association (ACA) Code of Ethics (ASERVIC, 2009), that this program also supports and adopts.

1. The facilitator can describe the similarities and differences between spirituality and religion, including the basic beliefs of various spiritual systems, major world religions, agnosticism, and atheism.
2. The facilitator recognizes that the participant's beliefs (or absence of beliefs) about spirituality and/or religion are central to his or her worldview and can influence psychosocial functioning.
3. The facilitator actively explores his or her own attitudes, beliefs, and values about spirituality and/or religion.
4. The facilitator continuously evaluates the influence of his or her own spiritual and/or religious beliefs and values on the participant and the program facilitation process.
5. The facilitator can identify the limits of his or her understanding of the participant's spiritual and/or religious perspective and is acquainted with religious and spiritual resources, including leaders, who can be avenues for consultation and to whom the facilitator can refer.
6. The facilitator can describe and apply various models of spiritual and/or religious development and their relationship to human development.
7. The facilitator responds to participant communications about spirituality and/or religion with acceptance and sensitivity.
8. The facilitator uses spiritual and/or religious concepts that are consistent with the participant's spiritual and/or religious perspectives and that are acceptable to the participant.

9. The facilitator can recognize spiritual and/or religious themes in participant communication and is able to address these with the participant when they are appropriate and relevant.
10. As applicable, and during the intake and assessment processes, the facilitator strives to understand a participant's spiritual and/or religious perspective by gathering information from the participant and/or other sources.
11. As applicable, when making a diagnosis, the facilitator recognizes that the participant's spiritual and/or religious perspectives can a) enhance well-being; b) contribute to participant problems; and/or c) exacerbate symptoms.
12. As applicable, the facilitator sets goals with the participant that are consistent with the participant's spiritual and/or religious perspectives.
13. As applicable, the facilitator is able to a) modify therapeutic techniques to include a participant's spiritual and/or religious perspectives, and b) utilize spiritual and/or religious practices as techniques when appropriate and acceptable to a participant's viewpoint.
14. As applicable, the facilitator can therapeutically apply theory and current research supporting the inclusion of a participant's spiritual and/or religious perspectives and practices.

Participant Rights – Clinical Professionals

When this program is facilitated in a healthcare facility, participants have rights according to most state regulations and national accreditations. Facilitators should be competent in these rights, and the most applicable rights regarding this program are the right to be included in their treatment planning and non-discrimination based on religion. If the Wholistic Health Assessment © is utilized to determine progress or success, the participant should have access to their results through a medical records request.

Cultural Competence – Clinical Professionals

Even though the clinical team should be trained at hire and annually regarding cultural competence, Evans and Nelson (2021) recommended that professionals do not assume that they understand the participant's beliefs and culture based on prior training, knowledge, or experiences. They recommend asking open ended questions as opposed to making suggestions or asking closed ended questions, such as "what brings you the greatest sense of

peace in your life" and "what activities bring you comfort (e.g. prayer, walks in nature, meditation, etc.). Sollecito et al. (2013) stated that the future of healthcare is focused on personalization of treatment and that participants' values may be one of the leading factors in their health care choices. When clinical team members come from markedly different socioeconomic and/or cultural backgrounds than their participant, it's possible to project their frames of reference onto the participant. Participants could assume that they are being judged negatively because of these differences or feel misunderstood. Asking questions, instead of making suggestions, helps to ensure personalized understanding.

Participant Screening – Clinical Professionals

During admission, the participants' religious preferences should be documented and whether they want to incorporate spiritual health into their treatment. Additionally, participants' traumatic experiences should be documented. There is substantial evidence that without direct screening, many participants will not reveal trauma histories. However, when asked directly, many will. The Wholistic Health Program © utilizes a list of traumatic experiences, highlighted on the Wholistic Health Assessment ©.

Treatment Planning – Clinical Professionals

In a professional facility the participant's objectives and goals identified in the Wholistic Health Program © should be incorporated into their individualized treatment plan. For example, the habits they choose to remove from their lives in Exercise 1 and the habits they choose to add to their lives in Exercise 2 are objectives. Their goals are what they plan to do to accomplish their objectives. This can include, but is not limited to, making consistent progress and completing this program, staying in contact with their peer support (if applicable), as well as any spiritual health goals as applicable (e.g. read religious text at least once per week).

Professional Tolerance – Clinical Professional

It's important that the clinical team is able to tolerate hearing and talking about participants' trauma. Some stories may be graphic and distressing, however, there is evidence that the more someone is able to discuss a traumatic experience without extreme distress, the more likely they are to decrease the traumatic impact. For this reason, it is recommended that professionals have support and regular self-care to avoid emotional and compassion fatigue.

Participant Length of Stay – Clinical Professional

Although this program is designed for 21 days, it is important for the participant to move at a pace that they can tolerate, even if the timeframe is more than the planned or recommended timeframe.

Follow Up Care – Clinical Professional

For more efficient but effective follow up care, professionals can add participants to an email list with proper consent. An email can be sent once every 30 days for at least 90 days (or until they unsubscribe). The email can include a short message encouraging them to continue reinforcing the concepts they learned during the program. For example, "Have you considered writing your affirmations and posting them on your refrigerator, mirror, or next to your computer screen?" or "Is your environment and entertainment still good for you? If not, what changes can you make today?" Typically, this level of follow up is sufficient for accreditation and regulatory compliance as well.

THERAPIES AND TECHNIQUES

Neuroplasticity Cognitive Training

Neuroplasticity is the brain's ability to change and adapt and the goal of neuroplasticity cognitive training is to improve behavior by driving adaptive changes through carefully designed exercises (Cramer et al. 2011). Some of our mental health can be characterized by limbic, prefrontal and frontostriatal neural circuits that underlie motivation, perception, cognition, behavior, social interactions and regulation of emotion (Beauregard et al., 2001). Typically, there are changes in key neural systems underlying thoughts, emotions, and complex behaviors. They are also heavily influenced by our experiences, environment, stressors, trauma, and social attachments (Grossman et al., 2003; Leonardo and Hen, 2008). In short, the brain has the ability to change, reorganize, or grow neural networks based on consistent exposure to thoughts, experiences, environment, relationships, etc. In the same way physical training can improve physical ability, cognitive training can improve cognitive ability.

Some neuroplasticity strategies use adverse stimuli such as electrical shock or deep brain stimulation (Greenberg et al., 2010). Although some research has shown some success in these strategies (Mayberg et al., 2005; Lozano et al., 2008), this program does not utilize and does not support adverse stimuli for the purposes of which it was designed. In addition, studies have shown progressive worsening of conditions when adverse stimuli such as electric shock or deep brain stimulation ceased (Lujan et al., 2008). With this program model, utilizing cognitive behavior therapy, evidence suggests that as individuals learn to modify their cognitive representations and behavioral responses, widespread changes occur in frontal cognitive control systems and in limbic system activation (Goldapple et al., 2004; Kennedy et al., 2007; Farb et al., 2010).

Studies that utilized neuroplasticity cognitive training have shown changes in functional MRI brain activation and correlations with functional gains with individuals diagnosed with schizophrenia (Farb et al., 2010; Haut et al., 2010), dyslexia (Temple et al., 2003) and depression (Farb et al., 2010). McNab et al. (2009) also found that neuroplasticity cognitive training was associated with changes in the density of cortical dopamine D1 receptors in individuals with no mental health diagnosis. The Wholistic Health Program © is for those with or without health diagnoses and addresses neuroplasticity cognitive training through ten exercises.

Cognitive Behavior Therapy

The American Psychological Association (2017) highlights the three core principles of Cognitive Behavior Therapy (CBT), which are:

1. Psychological problems are based, in part, on unhelpful ways of thinking.
2. Psychological problems are based, in part, on learned patterns of unhelpful behavior.
3. People suffering from psychological problems can learn better ways of coping with them, thereby relieving their symptoms and becoming more effective in their lives.

The Wholistic Health Program © considers that each experience causes us to adjust our behavior to adapt to the environments we're in. For example, if we live in or were raised in a toxic environment, we may adjust our behavior to adapt to that environment by lashing out to protect ourselves or becoming quiet and retreating to try to mentally escape. As another example, if we were raised in a loving and highly educated family but found ourselves suddenly moving to a high crime area, we may adjust our behavior to adapt to that environment by acting tough or less "proper".

Considering our skillfulness in adjusting to environments, the Wholistic Health Program © addresses the environment we create for ourselves through our emotional responses, thoughts, words, relationships, and entertainment. It challenges the individual to recreate and reshape their ideal environment which encourages an adjustment in behavior.

Repetitive Behavior Redirection

Balogh et al. (2002) conducted a fear conditioning experiment where animals were placed in an environment for about two minutes followed by 30 seconds of white noise. During the last 2 seconds of white noise the animals were given a mild shock through a floor grid. The researcher reported that through repetition animals learned to fear the shock on the floor grid and because the white noise came before the floor shock, they learned to fear the white noise as well. This type of learning is referred to as cued and contextual fear conditioning (Maren 2001). The brain regions that are thought to be involved in the response to these types of fear conditioning are the amygdala and the hippocampus (Ji & Maren 2008) which are the same regions that process trauma.
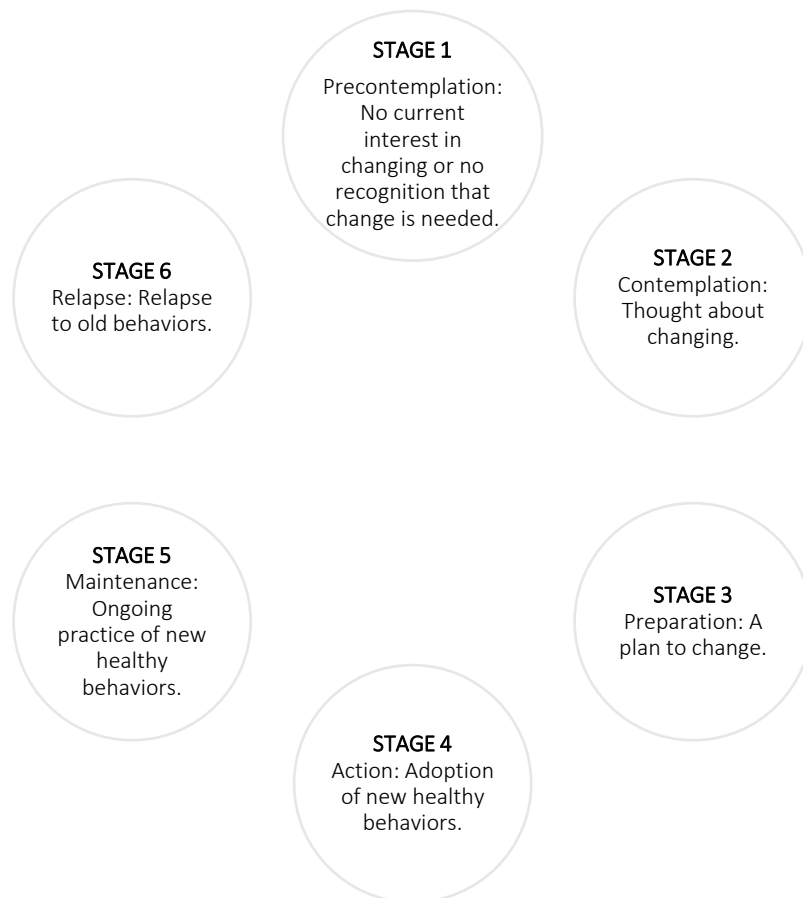
When a traumatic experience occurs, particularly multiple times, and especially in the same or similar environments, we are conditioned to be cautious of certain people and places associated with that experience. Just as we can be conditioned concerning traumatic experiences, we can be conditioned concerning any other repeated experience. Just as we can learn certain behaviors, we can unlearn and relearn new ones.

The behavior redirection techniques that Balogh et al. (2002) researchers used are considered "adverse stimuli". Again, the Wholistic Health Program © _does **not** use, encourage, or support this type of behavior redirection_. Instead, repetition is used similar to Response Interruption and Redirection (RIRD). RIRD consists of interrupting a negative response and redirecting to an alternative response (Ahern et al., 2007).

Stages of Change Model

The Stages of Change Model is part of the Transtheoretical Model (TTM) and focuses on long-term changes in health behavior (Prochaska & Di Clemente, 1982). The model proposes that people are at different stages of readiness to adopt healthy behaviors. Although individuals at stage 2 may benefit from the Wholistic Health Program ©, it may be most effective for individuals that are at stage 3 – 6.

STAGE 1
Precontemplation: No current interest in changing or no recognition that change is needed.

STAGE 6
Relapse: Relapse to old behaviors.

STAGE 2
Contemplation: Thought about changing.

STAGE 5
Maintenance: Ongoing practice of new healthy behaviors.

STAGE 3
Preparation: A plan to change.

STAGE 4
Action: Adoption of new healthy behaviors.

RESOURCES

Quick Questions and Answers

What are the benefits of the program?
The Wholistic Health Program © is designed with Neuroplasticity Cognitive Training techniques, Cognitive Behavior Therapy techniques, Repetitive Behavior Redirection techniques, and the Stages of Change Model to build neural pathways for habits that encourage healthy relationships, improved health, and an increased quality of life. The program shows evidence of positive outcomes by:

- Detoxing physically and mentally.
- Replacing unhealthy habits with positive habits.
- Increasing emotional intelligence.
- Practicing positive self-talk.
- Setting healthy boundaries with important people.
- Addressing and processing traumatic experiences.
- Reshaping the external environment.
- Reshaping inner circles.
- Addressing forgiveness.
- Overcoming fear.
- And many more factors scientifically found to impact relationships, health, and quality of life.

Who is this program for?
This program is facilitated with diverse groups in community settings, private practices, mental health facilities, wellness centers, etc. It is designed specifically for adults 18 years of age or older, although some community partners and professionals allow teens (13 - 17 years old) to participate with parental consent. The program is designed to be flexible, focusing on the individual needs and readiness of each person.

What type of relationships can this program help with?
The exercises in the program help participants practice core skills (e.g. setting boundaries, emotional intelligence, etc.) that can benefit any relationship, whether intimate, parental, social, or professional.

Does the program work best with certain mental health approaches or mental health issues?
The program is most effective with people that are between 3 and 6 on the Stages of Change Model (with 2 being the lowest recommended stage). It is also best for people that have none, mild, or controlled mental health issues. Individuals with severe mental health issues such as psychosis or schizophrenia should be stabilized first, before attempting to complete the program. Participants also respond best when motivational interviewing techniques are used during sessions, basically using open ended questions that explore the person's experiences, perspectives, and ideas.

How have clinical professionals incorporated the program into treatment?
The most common way clinical professionals and other facilitators have implemented the program is by:

1) Recommending the program to participants that range between 3 and 6 on the Stages of Change Model (with 2 being the lowest recommended stage).

2) Adding the program and exercises as action items on the patient or client's treatment or health plan.

3) Meeting with the participant once per week (or another agreed schedule) to process the exercises as they complete them, either in person or virtually. Example schedules for individual and group sessions can be found in the Facilitators Guide.

4) Requesting that participants complete the Wholistic Health Assessment at least once, to help participants see and target areas of improvement. This can be at the beginning or end of the program, however the most helpful timeframe for assessment is before and after the program to gauge improvement. Practices that do not have resources to properly collect and analyze the assessment can contract these services through Outcomes Excellence. Contact program@OutcomesExcellence.org if this is needed.

How have health facilities incorporated the program?
The program is designed to be flexible and solve top regulatory and accreditation issues including having individualized and personalized treatment plans, using evidence-based programs, and incorporating spiritual health into treatment which is optional based on individual beliefs. Due to its flexibility health facilities have incorporated the program in a

variety of ways that meet their mission and patient needs. The program is especially effective with outpatient and residential programs, and can be facilitated by a clinical professional with group or individual sessions. The Spiritual Health Component is optional for patients and employees and can be omitted as needed.

How much does it cost to implement the program?

The Wholistic Health Program © is currently $29.99 per workbook. Facilities may need to consider indirect costs, such as working with IT to implement the assessment electronically or contracting with Outcomes Excellence to provide participant assessment results. Although using the Wholistic Health Assessment is optional, having a consistent and scientifically reliable and valid method for assessing patient outcomes is best practice. Optional training can also be requested for clinical employees or facilitators as needed. Facilities cover travel expenses (e.g. rental car, flight, hotel if necessary) with a minimum of four hours for training at $500 per hour (whether in person or virtual).

How do I become a certified facilitator?

As an evidence-based program there are certain aspects that make the Wholistic Health Program © effective. For this reason, although it's not required, it's highly recommended that facilitators be certified to ensure quality programming. There are seven steps to being acknowledged as a certified facilitator:

1) Watch the Wholistic Health Program © Facilitator's Training.
2) Review the Facilitator's Guide.
3) Purchase the Wholistic Health Program ©.
4) Mentally Prepare for the 21 Day Detox and Fast.
5) Complete the Program as a Participant.
6) Complete the Facilitators Competency Test.
7) Assist with and Shadow a Live Facilitation.

Once you complete the training you will receive an official certificate as a "Certified Facilitator of the Wholistic Health Program ©". Training is coordinated through Outcomes Excellence. Visit the www.OutcomesExcellence.org for more information on the training and contact program@OutcomesExcellence.org if you have questions.

Do participants receive a certificate after completing the program?

A certificate of completion certifies that someone completed the program. This is optional and can be provided when requested or to all participants. Someone may request a certificate of completion for several reasons: they're required to show effort of personal development, the visual reward encourages continued improvement, they're tracking their journey, etc. To receive a certificate of completion participants should complete the Wholistic Health Assessment © and the program must be completed with a certified facilitator.

How can we use the program to show compliance with rules and standards?

You may email to request the official statement on the Wholistic Health Program © which outlines its evidence-based practices, uses, and benefits. This statement can be provided or placed in the policy and procedure binder that surveyors and auditors typically request. In addition, they are looking for actual implementation evidenced in participant health records. Tying the program into treatment objectives and progress notes is essential. For consultation on how this could be improved please contact program@OutcomesExcellence.org.

Example Facilitator Competency Test

*This is an example of what to expect during the competency test for certified facilitators. Questions can change.

1. <u>Although the program is flexible, what is the recommended timeframe for completion?</u>

   a) 4 Weeks
   b) 3 Weeks
   c) 10 Weeks
   d) 1 Year

2. <u>Everyone must complete the spiritual health component for accuracy.</u>

   a) True
   b) False

3. <u>This program is best for which people:</u>

   a) People who are on stage 3-6 on the Stages of Change Model
   b) People who have none, mild, or stable mental health issues
   c) Anyone interested in self-improvement
   d) All of the above
   e) None of the above

4. <u>This program is evidence based because:</u>

   a) Extensive research was reviewed to develop the program
   b) Data was collected and analyzed to develop the program
   c) The program was piloted and tested
   d) Sound models and techniques were incorporated into the exercises
   e) All of the above

5. <u>This program is so flexible that participants can skip any exercise and still receive the same results.</u>

   a) True
   b) False

6. When should participants NOT be screened for the program?

    a) When a clinical professional is treating them
    b) When the program is being offered in the general community
    c) When they are considered a patient or participant
    d) Everyone should be screened

7. How should participants be screened prior to completing the program? (Check all that apply)

    a) Consider their readiness to change based on the Stages of Change Model
    b) Consider their mental stability and ability to process past trauma
    c) Consider their financial ability to pay for the program
    d) Consider their religious preference and whether they want to complete the Spiritual Health Component

8. Neuroplasticity Cognitive Training is incorporated into this program through:

    a) Ten exercises that help people change their thought pattern through repetition.
    b) Ten exercises that help change, reorganize, or grow neural networks through consistent exposure to thoughts, experiences, environment, relationships, etc.
    c) Ten exercises that help unlearn damaging behavior and practice healthy behaviors.
    d) None of the above

9. Repetitive Behavior Redirection is incorporated into this program through:

    a) Ten exercises that help people change their thought pattern through repetition.
    b) Ten exercises that help change, reorganize, or grow neural networks through consistent exposure to thoughts, experiences, environment, relationships, etc.
    c) Ten exercises that help unlearn damaging behavior and practice healthy behaviors.
    d) None of the above

10. Cognitive Behavior Therapy is incorporated into this program through:

    a) Ten exercises that help people change their thought pattern through repetition.
    b) Ten exercises that help change, reorganize, or grow neural networks through consistent exposure to thoughts, experiences, environment, relationships, etc.
    c) Ten exercises that help unlearn damaging behavior and practice healthy behaviors.
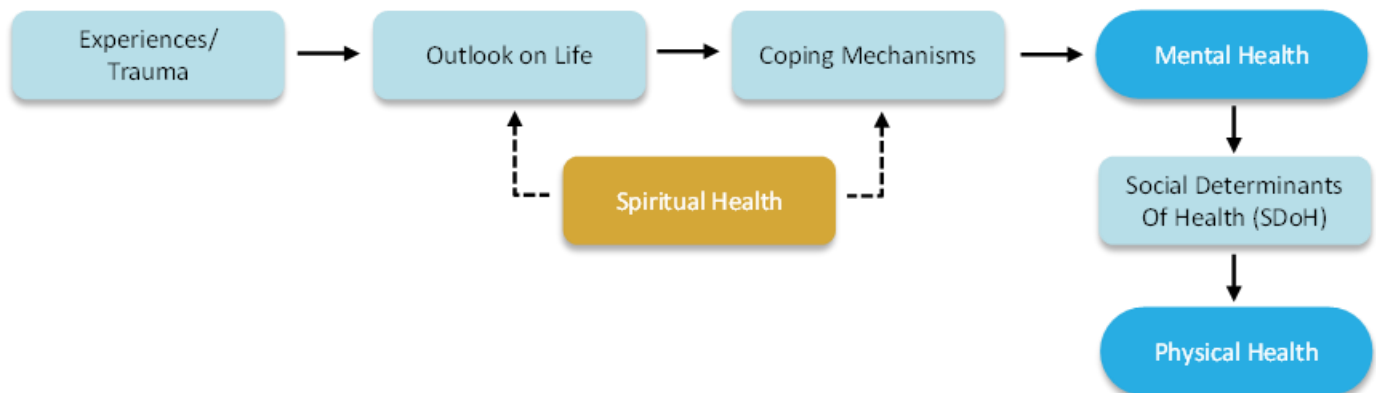   d) None of the above

Literature Review

The literature review is organized into the following sections: Conceptual Framework, Construct Definitions, Relationships, Trauma Impact, Spiritual Health, Outlook on Life, Coping Mechanisms, and Mental and Physical Health.

Conceptual Framework

The conceptual framework is derived from extent literature and data analysis from the Wholistic Health Assessment ©. The framework shows that when traumatic experiences occur they shape our outlook on life. Outlook on life influences coping mechanisms which impact mental health. Mental health impacts social determinants of health such as education, job status, income, housing status, and marital status. Social determinants of health impact physical health. Spiritual health can influence outlook on life and coping mechanisms.

Construct Definitions

- Wholistic: Characterized by the belief that the parts of something are interconnected and can be explained only by reference to the whole.

- Trauma: An event, or series of events, that causes or caused moderate to severe stress reactions.

- Outlook on Life: The extent to which people feel that life is meaningful, manageable, and comprehensible

- Coping Mechanism: Actions that people use to deal with the internal and/or external demands of stressful encounters.

- Mental Health: The capacity to feel, think, and act in ways that enable people to value and engage in life.

- Social Determinants of Health: Non-medical factors that influence health outcomes.

- Physical Health: The well-being of the physical body and proper functioning of the human organism.

- Spiritual Health: A person's faith and relationship with a higher power in finding meaning and connection with self and all creation.

Relationships

Hallowell (1999) defined connection as "feeling a part of something larger than yourself, feeling close to another person or group, feeling welcomed, and understood". Shaya et al. (2014) studied adults with type 2 diabetes and randomly assigned participants to a group. Group one received standard education sessions about diabetes and group two received diabetes education that focused on peer support and small groups. After 6 months, group two had a larger reduction in HbA1c and blood glucose and more favorable outcomes regarding weight, quality of life, self-efficacy, social network scores, and diabetes knowledge.

Engebretson et al. (2014) interviewed 14 cancer survivors who lived an average of 11 years after their diagnosis. The most consistent theme among them were their strong connections to family, friends, and medical staff which increased their desire to live. Jones et al. (2012) studied 93 individuals that were diagnosed with head injuries. The participants completed questionnaires 2 weeks after injury and again in 3 months. The questionnaires asked about their sense of belonging, connection, and support associated with group memberships. Participants that formed new group memberships 2 weeks after their injury had lower levels of post-traumatic stress symptoms at 3 months.

Pemu (2021) compared the success of professional health coaches and volunteer health coaches in a church, using the same program, and found that volunteer health coaches had the same or better results than professional health coaches. When her team assessed why, they found that church health coaches utilized their connection to the recipients' relationships to foster a change in behavior. In the 1950's, Maslow's Hierarchy of Needs also recognized the necessity of relationships, belonging, and connection.

Trauma Impact

Regulatory and accreditation entities require trauma informed care for patients and participants receiving treatment, for example, Joint Commission touts that their requirements are "grounded in trauma-informed practices" (Joint Commission, n.d.). This is the primary reason why trauma is a requirement for this study, to ensure the results are trauma informed. In addition, there is growing evidence of the importance of trauma informed care regarding mental and physical health outcomes. For example, the WHO World Mental Health Survey Collaborators (2017) reviewed 14 research articles, comprising 16,277 cases and 77,586

controls. This study found "highly suggestive evidence" of an association between psychological trauma at any point in time, including childhood, and any mental disorder. The results also showed specific types of traumas linked to specific disorders such as emotional abuse linked with anxiety. In addition, physical abuse and sexual abuse were linked with a range of mental disorders.

In 2019, 19.3 million Americans had a substance use disorder (SUD) and 13.1 million had a serious mental health illness (SMI) which was approximately 6% more than 2018 (SAMHSA, 2020). In 2021, 43.6 million Americans had a substance use disorder (SUD) and 14.1 million had a serious mental health illness (SMI) which was a 56% increase for SUD and a 7% increase for SMI (SAMHSA, 2022). Forty five percent of children reported experiencing at least one type of trauma in the United States (Sacks et al., 2014) and 72% in Canada (Chartier et al., 2010). WHO assessed 68,894 adults in 24 countries for 29 lifetime traumas and found that 70.4% experienced at least one trauma, with an average of at least three traumas (WHO World Mental Health Survey Collaborators, 2017).

The Center for Disease Control (2019) linked trauma to mental and physical health stating that at least five of the top 10 leading causes of death are associated with childhood trauma, including heart disease, cancer, respiratory diseases, diabetes, and suicide. Center for Community Research (2017) highlighted that a person's risk for alcoholism, illicit drug use, engaging in risky sexual behaviors, suicide attempts, and smoking all increase proportionally to the number of traumatic experiences during childhood.

Ruglass et al. (2015) reflected on Talbot, 2009 where 163 psychiatric patients over the age of 50 were studied and findings showed that patients who were raped as children had more medical conditions, worse physical functioning, and more pain than patients who had not been sexually assaulted. In terms of overall medical conditions, the effect of rape was comparable to adding eight years of chronological age. Regarding activities of daily living and bodily pain, rape in childhood was comparable to adding 20 years of chronological age. Growing research supports the impact that trauma has on mental and physical health. Regarding trauma's connection to spiritual health, Zeligman et al. (2021) utilized regression analysis to study 151 undergraduate students and found that hope, gratitude, and optimism (which were defined as spiritual health constructs) helped buffer negative effects of post-traumatic stress, while also positively contributing to post traumatic growth.

Spiritual Health

The World Health Organization (WHO, 2012) developed an assessment consisting of factors that contribute to quality of life and determined "spirituality / religion / personal beliefs" is a factor. Cheng et al. (2020) conducted a study using propensity score matching and treatment effect to determine causal inference between religious beliefs and mental health and found that religious belief can promote mental health. Upenieks (2021) utilized Ordinary Least Squares (OLS) Regression to study whether religiosity between childhood and adulthood had an effect on mental health for 1,431 patients diagnosed with cancer and found that patients reported considerably lower psychological distress if they also reported "high or increasing" religious importance. Jung (2018) utilized Ordinary Least Squares (OLS) Regression to study 1,635 adults through secondary data and found that individuals who experienced childhood adversity had reduced effect on their mental health when involved in religious practices. Debnam et al. (2016) utilized multilevel structural equation models to study 5,217 students and found that adolescents who frequently attend religious services, are involved in faith-based activities, and place a high value on spirituality exhibit greater resilience when facing stressors that can lead to the use of drugs and alcohol as a coping mechanism.

Zeligman et al. (2020) utilized bivariate correlations, multiple regression, and moderation analyses to study 222 university students and found that religion and spirituality accounted for 7% of the variance in post-traumatic growth, which was defined as perceived growth and positive life changes following trauma. Buser et al. (2020) utilized hierarchical regression analysis to study the association between anxious and avoidant attachment to God and non-suicidal self-injury (NSSI), such as hair pulling and biting, with 516 adults and found that individuals who worry about God or a higher power abandoning them and questions divine compassion and attention report higher rates of NSSI.

In addition, Buser et al. (2020) reported that individuals who are distanced from God or a higher power or avoid intimacy in this form of relationship also report higher rates of NSSI. Wei et al. (2012) utilized regression analysis to study 183 Chinese Christians from seven Chinese churches located in five states and found that a secure attachment to God (which is similar to spiritual health) has a direct effect, but not a moderating effect, on life satisfaction or positive affect (which is similar to outlook on life). However, Wei et al. (2012) found that avoidant attachment to God had a direct and moderating effect on life satisfaction and positive affect.

Li et al. (2016) utilized multivariate logistic regression to study 48,984 women through secondary data and found that women had lower risk of developing depression when they reported frequent religious service attendance. Martin et al. (2015) utilized hierarchical multiple regression to study 116 participants in alcohol outpatient treatment and found that participants were less likely to drink heavily and had fewer drinks per day when they reported that they relied on religion, in comparison to those who believed in no religion or resorted to negative religious coping.

Mendes et al. (2022) utilized multivariate linear regression to study 72 patients with stable chronic obstructive pulmonary disease (COPD) and found that higher spirituality and less negative spiritual/religious coping was associated with reduced dyspnea, the burden of COPD, symptoms of anxiety and depression, and better quality of life. Hilton and Child (2014) utilized hierarchical regression analysis to study 60 older Latinos and found that externalizing religiosity was a predictor of well-being, although they did not have the appropriate sample size for hypothesis testing. Vallurupalli et al. (2012) utilized simple linear regression to study 69 patients with advanced illness and found a decrease psychologically and in overall quality of life when spiritual health was not addressed. Kelly et al. (2011) utilized regression analysis to study 195 youth and teens and found that higher spirituality was related to lower substance abuse in both males and females.

Although outdated, Hummer et al. (1999) showed stunning associations between religion and health. The study was conducted in the United States with 21,000 adults and found that people who had not attended a religious service had a risk of death over an eight-year period, 19 times higher than those that attended more than once per week. For individuals that were 20 years of age and attended a religious service more than once per week, their life expectancy was seven and a half years longer on average than those that did not attend (Hummer et al., 1999). Tavares et al. (2022) analyzed 136 studies using simultaneous concept analysis and one conclusion was that the concept of spiritual health being applied or tested practically in healthcare is still insufficiently developed. Tavares et al. (2022) stated that this topic requires more distinct theoretical definitions.

For 20 years, between 1999 and 2019, there has been an increase in healthcare costs for mental health from $40,287,000,000 to $137,672,000,000 and an increase in people requiring mental health services by 44% from 22,504,000 to 51,343,000 (Agency for Healthcare Research and Quality (AHRQ), n.d.). Hall and Powell (2021) stated that it is imperative to identify reforms

that can minimize healthcare costs by exploring interventions such as spiritual care. Lumb (2016) stated that spiritual health can decrease healthcare cost through chaplains that can provide proactive spiritual support to patients and professionals, helping to improve resiliency and increase professional engagement and quality of patient care. Regarding spiritual support for professionals, St. Onge et al. (2022) found that international medical graduates were significantly more likely to report spiritual health as a way to manage stress than medical graduates in the United States and were also 23% less likely to report burnout, where international burnout was 26% and U.S. was 49%.

Failing to consider spiritual needs can also cost more. Balboni et al. (2011) stated that cancer patients receiving less spiritual support during treatment generated higher care costs, typically with longer lengths of stay in intensive care units instead of hospice. Specifically, cost for cancer patients at the end of life were $4,947 for those whose spiritual needs were not supported and $2,833 for those whose spiritual needs were supported (Balboni et al., 2011). The cost difference for patients that reported high religious coping was $6,344 for those who weren't supported spiritually and $2,431 for patients that were (Balboni et al., 2011). Newer research was not found regarding the impact of spiritual health on healthcare cost; therefore, the Personal Consumption Expenditure (PCE) health component price index was used to adjust for inflation (Dunn et al., 2018). As of 2021, the figures that Balboni et al. (2011) reported, was equivalent to $5,822 and $7,466 for those whose spiritual needs were not supported in comparison to $3,334 and $2,861 for those who were supported, respectively (Agency for Healthcare Research and Quality, 2022).

Outlook on Life

Kato et al. (2015) studied older adults between 98 and 107 years old that did not have significant cognitive impairment and adjusted for history of medical illnesses, cognitive function, and demographic variables. Researchers found that a positive outlook on life was associated with health outcomes and concluded that positive attitudes and emotions may have "protective effects" on mental health as people age. Although slightly outdated, the literature review Lyubomirsky et al. (2005) completed on outlook on life was impressive. It is composed of 225 papers, comprising over 275,000 participants. Their review revealed that positive affect and mood fosters strong bodies and immune systems. Conversano et al. (2010) state that optimism may significantly influence mental and physical well-being by the promotion of a healthy lifestyle. Walter et al. (2019) utilized an experimental intervention program to study 117

junior athletes' and found that positive self-talk interventions improved their psychological states and performance.

Research also shows that social connections and support systems impact outlook on life, with Engebretson, et al. (2014) interviewing 14 cancer survivors who lived an average of 11 years after their diagnosis. The most consistent theme among them were their strong connections to family, friends, and medical staff which increased their desire to live. Shaya et al. (2014) studied adults with Type 2 diabetes and randomly assigned participants to a group. Group one received standard education sessions about diabetes and group two received diabetes education that focused on peer support and small groups. After 6 months, group two had a larger reduction in HbA1c and blood glucose and more favorable outcomes regarding weight, quality of life, self-efficacy, social network scores, and diabetes knowledge. Jones et al. (2012) studied 93 individuals that were diagnosed with head injuries. The participants completed questionnaires two weeks after injury and again in three months. The questionnaires asked about their sense of belonging, connection, and support associated with group memberships. Participants that formed new group memberships two weeks after their injury had lower levels of post-traumatic stress symptoms at three months (Jones et al., (2012).

Research also suggests that spiritual health improves emotional intelligence, and people with higher emotional intelligence have a healthier outlook on life with better physical and mental health outcomes (Raghibi & Gharahchaghi, 2013). Chen et al. (2022) surveyed 105 nurses to investigate whether there was a relationship between outlook on life including emotional regulation and mental health and found that these variables were "significantly correlated". Akbari and Hossaini (2018) utilized hierarchal regression analysis to study 231 staff from Baqiyatallah University of Medical Sciences and found a statistically significant relationship between quality of life including emotional regulation and spiritual health. Bożek et al. (2020) utilized path analysis and linear regression to study 595 students from six different universities and found that spiritual health, and health-related behaviors, specifically positive attitude, were directly related to mental health. They also concluded that there is an indirect path between spiritual health and mental health.

Coping Mechanisms

Mullen et al. (2017) utilized structural equation modeling to study 140 counselors and stated that coping occurs when a situation is strenuous or exceed an individual's resources and when

an individual does not have the ability to cope, they experience stress. Research such as Shonkoff et al. (2011) documented that it is the adoption of unhealthy coping mechanisms and lifestyles in reaction to trauma that leads to poor health and up to 40% of early deaths have been estimated to be the result of behavioral or lifestyle patterns. SAMHSA (2018) also linked trauma to coping mechanisms and coping mechanisms to health outcomes, stating that when trauma is not addressed or if it's managed with negative coping mechanisms, it can lead to mental and physical health issues. Grim (2019) stated that people often choose negative coping skills to manage negative experiences such as trauma and Burns et al. (2016) utilized cross-sectional and prospective analysis to study 1,742 adults with Type 2 diabetes which showed a connection between coping and mental health.

Burns et al. (2016) stated that is unclear whether coping mechanisms impact mental health, mental health impacts coping mechanisms, or whether there is a third variable affecting coping mechanisms and mental health. In addition, although the link between coping mechanisms and mental and physical health are strong, there are some assumptions that spiritual health may have a positive impact on mental and physical health due to spiritual health impacting coping mechanisms. For example, Harris et al. (2021) utilized hierarchical binomial logistic regression to study 488 Christian African Americans and found that religious coping statistically accounted for variance in whether individuals seek counseling for mental health.

Ozcan et al. (2021) stated that spiritual beliefs may lessen negative interpretations of crises and enable people to stay calm in uncertain situations. Aten et al. (2014) stated that engagement in spiritual practices helps people to feel grounded and deal with high levels of uncertainty. Coppola et al. (2021) stated that spiritual health provides comfort in uncomfortable situations. Jeter and Brannon (2016) utilized analysis of variance (ANOVA) to study 300 undergraduate students and stated that religious coping reduces revenge seeking behaviors and increases reconciliation behaviors when someone is offended. Research continues to gather participant feedback regarding how they use spiritual health, to build the concept that spiritual health impacts coping mechanisms (Algahtani et al., 2022).

However, scientific studies are showing no relationship between spiritual health and coping mechanisms, specifically when utilizing principal component analysis to study spiritual and religious affiliation with 279 combat-deployed military personnel (Sterner and Jackson-Cherry, 2015). Ito and Matsushima (2017)) utilized one-way analysis of variance (ANOVA) when studying 201 adults and found that the relationship between religion as a coping mechanism

and specific health outcomes (i.e. blood pressure, high-density lipoprotein cholesterol, and low-density lipoprotein cholesterol) was statistically insignificant. Although there appears to be a relationship between coping mechanisms and spiritual health, no research has been found that confirms what the relationship may be.

Mental and Physical Health

Ohrnberger et al. (2017) utilized a longitudinal design with mediation analysis to study 10,693 individuals in the United Kingdom aged 50 years and older between 2002 and 2012. The study found that mental health has a statistically significant, direct and indirect, effect on physical health and physical health also has a statistically significant, direct and indirect, effect on mental health. Torres et al. (2023) utilized linear regression analysis to study 90 undergraduate students in the United States and found that mental health symptoms had a statistically significant effect on the deterioration in overall body composition. In addition, and alternatively, body composition had a statistically significant effect on mental health symptoms such as depression and anxiety. The study recommended strategies to reduce stress, anxiety, and depression and improve nutrition and physical activity.

Although the studies above show bidirectional impact between physical and mental health, a growing number of studies show that physical health has a larger impact on mental health than mental health has on physical health. Ai et al. (2021) utilized conceptual analysis and developed a conceptual framework that showed physical activity impacting mental health, in context of required isolation and quarantines during COVID. The study concluded that physical activity is necessary for maintaining mental health and well-being and recommended interventions that encourage physical activities particularly during health crises.

Jansen et al. (2022) utilized a longitudinal design over one year to study 430 British undergraduate students and found that general physical health predicted general mental health including aspects of mental health such as depression, anxiety, and stress. In addition, anxiety predicted general physical health including aspects of physical health such as pain. However, general mental health was not a predictor of general physical health, so the study concluded that general physical health appears to exacerbate mental health issues more than mental health issues leading to physical health issues. The study also recommends that early interventions integrate physical and mental health solutions collectively rather than focusing on one aspect.

Doan et al. (2023) utilized a longitudinal design with Ordinary Least Squares analysis to study 24,966 individuals over the age of 15, spanning 18 years between 2002 and 2019 with data from the Household Income and Labour Dynamics in Australian Survey (HILDA). The study found that physical health is a driver of mental health, although the study did not examine the impact mental health may have on physical health. In addition, this study recommended dual treatment of mental and physical health issues rather than focusing on one aspect or both as separate specialties.

Ronaldson et al. (2021) collected data from 22 assessment centers in England, Scotland, and Wales between 2006 and 2010. In 2016, 154,367 of these patients (middle aged) responded to a mental health questionnaire and results were analyzed utilizing exploratory factor analysis. The study found that physical multimorbidity was statistically associated with mental health disorders such as depression and anxiety. The study found the highest association among individuals with physical health issues such as pain or gastrointestinal issues. In addition, and similar to other studies, the recommendation was to integrate mental and physical treatment.

Most of the peer reviewed publications found regarding the relationship between mental and physical health are in countries outside of the United States, such as England, Scotland, and Australia. It is these countries that are calling for an innovative approach to integrate mental and physical health treatment. The United States experiences worsening health outcomes in comparison to other high-income nations (Gunja et al., 2023). Gunja et al. (2023) reported the United States as having the highest healthcare expenditures among peer countries (Figure B3), while also ranking highest in infant and maternal mortality (Figure B4), self-harm deaths (Figure B5), obesity (Figure B6), and multiple chronic conditions (Figure B7).

Benatar et al. (2021) noted that the average life expectancy for people in Cuba is 79 years of age which was the same as the United States (U.S.), while the U.S. per capita income was approximately eight times the amount of Cuba. The author found this scenario consistently, where countries with significantly low per capita income averaged the same or exceeded the life expectancy in the United States. To best serve health care needs in the U.S., thorough reviews and synthesis of the literature is crucial, including practical application of the findings, and rules, regulations, and standards that are based on evidence.

References

Abnet, C. C. (2007). Carcinogenic Food Contaminants. *Cancer Investigation, 25*(3), 189-196.

Ahearn, W. H., Clark, K. M., MacDonald, R. P. F., & Chung, B. I. (2007). Assessing and treating vocal stereotypy in children with autism. *Journal of Applied Behavior Analysis*, *40*(2), 263-275.

Ajilchi, B. & Kargar, F. R. (2013). The impact of a parenting skills training program on stressed mothers and their childrens depression level. *Procedia - Social and Behavioral Sciences*, *84*, 450-456.

American Counseling Association. (2014). *ACA code of ethics*. Retrieved from https://www.counseling.org/resources/aca-code-of-ethics.pdf.

American Psychological Association. (2017). What is Cognitive Behavioral Therapy? Retrieved from https://www.apa.org/ptsd-guideline/patients-and-families/cognitive-behavioral.

American Psychological Association. (2018). Life Saving Relationships. Retrieved from https://www.apa.org/monitor/2018/03/life-saving-relationships.

Association for Spiritual, Ethical, and Religious Values in Counseling (ASERVIC). (2009). *Competencies for addressing spiritual and religious issues in counseling*. Retrieved from http://www.aservic.org/resources/spiritual-competencies/.

Atkins, M. S., Rusch, D., Mehta, T. G., & Lakind, D. (2016). Future directions for dissemination and implementation science: Aligning ecological theory and public health to close the research to practice gap. *Journal of Clinical Child & Adolescent Psychology, 45*(2), 215-226. Doi:10.1080/15374416.2015.1050724.

Balogh, S. A., Radcliffe, R. A., Logue, S. F. & Wehner, J. M. (2002). Contextual and cued fear conditioning in C57Bl/6J and DBa/2J mice: Context discrimination and the effects of retention interval. *Behavioral Neuroscience, 116*(6), 947-957.

Beauregard, M., Levesque, J., & Bourgouin, P. (2001). Neural correlates of conscious self-regulation of emotion. *Journal of Neuroscience, 21*(18), RC165. Doi:10.1523/JNEUROSCI.21-18-j0001.2001.

Benatar, S. & Brock, G. (2021). *Global health: Ethical challenges (2nd ed.).* Cambridge University Press. Doi:10.1017/9781108692137.

Boscarino, J. A. (1995). Post-traumatic stress and associated disorders among Vietnam veterans: The significance of combat exposure and social support. *Journal of Traumatic Stress, 8*(2), 317-336.

Brittain, H. G., & Florey, K. (1998). Metformin Hydrochloride. In *Analytical profiles of drug substances and excipients*, 243-293. Academic Press.

Brown, Brene. (2017). *Rising strong as a spiritual practice*. Sounds True Publishing.

Bruckner, J. J., Stednitz, S. J., Grice, M. Z., Zaidan, D., Massaquoi, M. S., Larsch, J., Tallafuss, A., Guillemin, K., Washbourne, P., Eisen, J. S. (2022). The microbiota promotes social behavior by modulating microglial remodeling of forebrain neurons. *PLOS Biology*. Doi:10.1371/journal.pbio.3001838.

Burns, R. J., Deschênes, S. S., & Schmitz, N. (2016). Associations between coping strategies and mental health in individuals with type 2 diabetes: Prospective analyses. *Journal of Health Psychology, 35*(1), 78-86. Doi:10.1037/hea0000250.

Centers for Disease Control. (2019). About the CDC-kaiser ACE study. Retrieved from https://www.cdc.gov/violenceprevention/childabuseandneglect/acestudy/about.html.

Centers for Disease Control. (2019). Preventing child abuse & neglect. Retrieved from https://www.cdc.gov/violenceprevention/childabuseandneglect/fastfact.html.

Clark, P. A., Drain, M., & Malone, M. P. (2003). Addressing Patients' Emotional and Spiritual Needs. *The Joint Commission Journal on Quality and Safety*, *29*(12), 659-670.

Chuang,H. & Chen, C. (2020). Exploring the treatment effect of religious belief toward mental health with propensity score matching. *Kybernetes*. Doi:10.1108/K-11-2020-0745.

Conversano, C., Rotondo, A., Lensi, E., Della Vista, O., Arpone, F., & Antonio Reda, M. (2010). Optimism and its impact on mental and physical well-being. *Clinical Practice Epidemiology Mental Health*, *6,* 25-29. Doi:10.2174/1745017901006010025.

Cramer, S. C., Sur, M., Dobkin, B. H., O'Brien, C., Sanger, T. D., Trojanowski, J. Q., Rumsey, J. M., Hicks, R., Cameron, J., Chen, D., Chen, W. G., Cohen, L. G., deCharms, C., Duffy, C. J., Eden, G. F., Fetz, E. E., Filart, R., Freund, M., Grant, S. J., Haber, S., Kalivas, P. W., Kolb, B., Kramer, A. F., Lynch, M., Mayberg, H. S., McQuillen, P. S., Nitkin, R., Pascual-Leone, A., Reuter-Lorenz, P., Schiff, N., Sharma, A., Shekim, L., Stryker, M., Sullivan, E. V., Vinogradov, S. (2011). Harnessing Neuroplasticity for Clinical Applications. *Brain, 134*(6), 1591-1609. Doi:10.1093/brain/awr039.

Debnam, K., Milam, A. J., Furr-Holden, C. D., & Bradshaw, C. (2016). The role of stress and Spirituality in adolescent substance use. *Substance Use and Misuse, 51*(6), 733-741.

Division of Water. (2019). City of Columbus Drinking Water Consumer Confidence Report. *Ohio Department of Public Utilities*.

Emoto, M. (2005). *The hidden messages in water*. Pocket.

Engebretson, J. C., Peterson, N. E., Frenkel, M. (2014). Exceptional patients: Narratives of connections. *Journal of Palliative and Supportive Care*, *12*(4), 269-276.

Farb, N. A., Anderson, A. K., Mayberg, H., Bean, J., McKeon, D., & Segal, Z. V. (2010). Minding one's emotions: Mindfulness training alters the neural expression of sadness. *Emotion, 10*(1), 25-33. Doi:10.1037/a0017151.

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., & Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. *American Journal of Preventive Medicine*, *14*(4), 245-258.

Glanz, K. (2016). *Social and Behavioral Theories*. Retrieved from https://obssr.od.nih.gov/wp-content/uploads/2016/05/Social-and-Behavioral-Theories.pdf.

Goldapple, K., Segal, Z., Garson, C., Lau, M., Bieling, P., Kennedy, S., & Mayberg, H. (2004). Modulation of cortical-limbic pathways in major depression: Treatment-specific effects of cognitive behavior therapy. *Archives of General Psychiatry, 61*(1), 34-41. Doi:10.1001/archpsyc.61.1.34.

Goleman, D. (2014). *Emotional intelligence*. Bloomsbury Publishing.
Greenberg, B. D., Rauch, S. L., & Haber, S. N. (2010). Invasive circuitry-based neurotherapeutics: stereotactic ablation and deep brain stimulation for OCD, *Neuropsychopharmacology, 35*(1), 317-336. Doi:10.1038/npp.2009.128.

Grim, B. J., & Grim, M. E. (2019). Belief, behavior, and belonging: How faith is indispensable in preventing and recovering from substance abuse. *Journal of Religion and Health*, *58*(5), 1713-1750.

Grossman, A. W., Churchill, J. D., McKinney, B. C., Kodish, I. M., Otte, S. L., Greenough, W. T. (2003). Experience effects on brain development: Possible contributions to psychopathology, *Journal of Child Psychology and Psychiatry, 44*, 33-63.

Hallowell, E. M. (1999). *Connect*. Pocket Books.

Haut, K. M. & Lim, K. O., Macdonald III, A. (2010). Prefrontal cortical changes following cognitive training in patients with chronic schizophrenia: Effects of practice, generalization, and specificity. *Neuropsychopharmacology, 35*(9), 1850-1859. Doi:10.1038/npp.2010.52.

Hummer, R. A., Rogers, R. G., Nam, C. B., & Ellison, C. G. (1999). Religious involvement and U.S. adult mortality. *Demography*, *36*(2), 273-285.

Ito, M. & Matsushima, E. (2017). *Presentation of coping strategies associated with physical and mental health during health check-ups*. Retrieved from www.ncbi.nlm.nih.gov/pmc/articles/PMC5337237.

Ji, J. Z. & Maren, S. (2008). Differential roles for hippocampal areas CA1 and CA3 in the contextual encoding and retrieval of extinguished fear. *Learning & Memory, 15*(4), 244-251.

Jiang, H., Ling, Z., Zhang, Y., Mao, H., Ma, Z., Yin, Y., Wang, W., Tang, W., Tan, Z., Shi, J., Li, L., Ruan, B. (2015). Altered fecal microbiota composition in patients with major depressive disorder. *Brain, Behavior, and Immunity, 48*, 186-194. Doi:10.1016/j.bbi.2015.03.016.

Jones, J. M., Williams, W. H., Jetten, J., Haslam, S. A., Harris, A., Gleibs, I. H. (2012). The role of psychological symptoms and social group memberships in the development of post-traumatic stress after traumatic injury. *British Journal of Health Psychology, 17*(4), 798-811.

Jung, J. H. (2018). Childhood adversity, religion, and change in adult mental health. *Research on Aging, 40*(2), 155-179. Doi:10.1177/0164027516686662.

Kelly, J. F., Pagano, M. E., Stout, R. L., & Johnson, S. M. (2011). Influence of religiosity on 12-step participation and treatment response among substance-dependent adolescents. *Journal of Studies on Alcohol and Drugs*, *72*(6), 1000-1011.

Kennedy, S. H., Konarski, J. Z., Segal, Z. V., Lau, M. A., Bieling, P. J., McIntyre, R. S., & Mayberg, H. S. (2007). Differences in brain glucose metabolism between responders to CBT and venlafaxine in a 16-week randomized controlled trial. *American Journal of Psychiatry, 164*(5), 778-788.

Leonardo, E. D. & Hen, R. (2008). Anxiety as a developmental disorder, *Neuropsychopharmacology, 33*, 134-140.

Li, S., Okereke, O. I., Chang, S. C., Kawachi, I., & VanderWeele, T. J. (2016). Religious service attendance and lower depression among women-a prospective cohort study. *Annals of Behavioral Medicine, 50*(6), 876-884. Doi:10.1007/s12160-016-9813-9.

Lin, N., Simeone, R. S., Ensel, W. M., & Kuo, W. (1979). Social support, stressful life events, and illness: A model and an empirical test. *Journal of Health and Social Behavior*, *20*(2), 108-119.

Literature review: Best prevention practices for reducing adverse childhood experiences (ACEs). (2017). Retrieved from https://www.ccrconsulting.org/images/mpi-resource-pdfs/evaluation_resources/CCR_ACEs-Literature-Review_Final_04-06-17.pdf.

Lozano, A. M., Mayberg, H. S., Giacobbe, P., Hamani, C., Craddock, R. C., & Kennedy, S. H. (2008). Subcallosal cingulate gyrus deep brain stimulation for treatment-resistant depression. *Biological Psychiatry, 64*(6), 461-467. Doi:10.1016/j.biopsych.2008.05.034.

Lujan, J. L., Chaturvedi, A., & McIntyre, C. C. (2008). Tracking the mechanism of deep brain stimulation for neuropsychiatric disorders, *Frontiers in Bioscience, 13*, 5892-5904. Doi:10.2741/3124.

Lyubomirsky, S., King, L., & Diener, E. (2005). The benefits of frequent positive affect: Does happiness lead to success? *Psychological Bulletin, 131*(6), 803-855. Doi:10.1037/0033-2909.131.6.803.

Mannarino, A., Mallah, K., Amaya-Jackson, L., Frank, B., Berliner, L., Cohen, J., Deblinger, E., Gully, K., Putnam, F., Denis Radigan, D., Rivera, S., Saunders, B., Allred, C., Burns, B., Power, E. (2004). *How to Implement Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)*. The National Child Traumatic Stress Network.

Manne, S. L., Pape, S. J., Taylor, K. L., Dougherty, J. (1999). Spouse support, coping, and mood among individuals with cancer. *Annals of Behavioral Medicine, 21*, 111-121.

Maren, S. (2001). Neurobiology of Pavlovian fear conditioning. *Annual Review of Neuroscience, 24*, 897-931.

Martin, R. A., Ellingsen, V. J., Tzilos, G. K., & Rohsenow, D. J. (2015). General and religious coping predict drinking outcomes for alcohol dependent adults in treatment. *The American Journal on Addictions, 24*(3), 240-245.

Maslow, A. H. (1954). *Motivation and Personality*. Harper & Brothers.

Mayberg, H. S., Lozano, A. M., Voon, V., McNeely, H. E., Seminowicz, D., Hamani, C., Schwalb, J. M., Kennedy, S. H. (2005). Deep brain stimulation for treatment-resistant depression. *Neuron, 45*(5), 651-660. Doi:10.1016/j.neuron.2005.02.014.

McCormack, B., van Dulmen, A. M., Eide, H., Skovdahl, Meier, A., Van Katwyk, P. L., & O'Connor, T. S. J. (2005). *Scared sick: The role of childhood trauma in adult disease*. Wilfrid Laurier University Press.

McCormack, B., van Dulmen, S., Eide, H., Skovdahl, K., & Eide, T. (2017). *Person-centered healthcare research*. Wiley.

McNab, F., Varrone, A., Farde, L., Jucaite, A., Bystritsky, P., Forssberg, H., & Klingberg, T. (2009). Changes in cortical dopamine D1 receptor binding associated with cognitive training. *Science, 323*(5915), 800-802. Doi:10.1126/science.1166102.

McNaught, A. D. & Wilkinson, A. (1997). *Compendium of Chemical Terminology (2nd ed)*. Blackwell Scientifics: Oxford.

Mee-Lee, D., Shulman, G. D., Fishman, M., Gastfriend, D. R., Miller, M. M., & Provence, S. M. (2013). *The ASAM criteria: Treatment for addictive, substance-related, and co-occurring conditions (3rd ed. p. 54).* The Change Companies.

Michalak, E. E., Wilkinson, C., Hood, K., Dowrick, C., Wilkinson, G. (2003). Seasonality, negative life events, and social support in a community sample. *British Journal of Psychiatry, 182,* 434-438.

Mohr, D. C., Classen, C., & Barrera Jr, M. (2004). The relationship between social support, depression, and treatment for depression in people with multiple sclerosis. *Psychological Medicine, 34*, 533-541.

Newberg, A. B., & Waldman, M. R. (2013). *Words can change your brain: 12 conversation strategies to build trust, resolve conflict, and increase intimacy*. A Plume Book.

Northwestern University. (2013). 'Love hormone' is two-faced: Oxytocin strengthens bad memories and can increase fear and anxiety. *ScienceDaily*. Retrieved from www.sciencedaily.com/releases/2013/07/130722123206.htm.

Oxman, T. E. and Hull, J. G. (2001). Social support and treatment response in older depressed primary care patients. *The Journals of Gerontology, Series B, Psychological Sciences and Social Sciences, 56*, 35-45.

Ozbay, F., Johnson,D. C., Dimoulas, E., Morgan III, C. A., Charney, D., Southwick, S. (2007). Social support and resilience to stress: From neurobiology to clinical practice. *Psychiatry (Edgmont), 4*(5), 35-40.

Paykel, E. S. (1994). Life events, social support and depression. *Acta Psychiatrica Scandinavica Supplementum, 377*, 50-58.

Pekarek, B. T. et al. (2022). Oxytocin signaling is necessary for synaptic maturation of adult-born neurons. Genes & Development. *Genes and Development.* Doi:10.1101/gad.349930.122.

Piccone, A. (2022). Presentation of Research Findings at 183rd Meeting of the Acoustical Society of America.

Prochaska, J. O. & Di Clemente, C. C., (1982). Transtheoretical therapy: Toward a more integrative model of change. *Psychotherapy: Theory, Research and Practice, 19*(3), 276-288. Puchalski, C., & Ferrell, B. (2010). *Making health care whole: Integrating spirituality into patient care*. Templeton Press.

Revenson, T. A., Schiaffino, K. M., Majerovitz, S. D., and Gibofsky, A. (1991). Social support as a double-edged sword: The relation of positive and problematic support to depression among rheumatoid arthritis patients. *Social Science & Medicine, 33*, 807-813.

Robert, T. E., & Kelly, V. A. (2014). *Critical Incidents in Integrating Spirituality into Counseling*. Wiley.

Ruglass, L. M. & Kendall-Tackett, K. A. (2015). *Psychology of trauma 101*. Springer.

Sacks, V., Murphey, D., & Moore, K. (2014). *Adverse childhood experiences: National and state-level prevalence*. Retrieved from https://www.childtrends.org/publications/ adverse-childhood-experiences-national-and-state-level-prevalence.

Sapolsky, R. M., Alberts S. C., & Altmann, J. (1997). Hypercortisolism associated with social subordinance or social isolation among wild baboons. *Archives of General Psychiatry, 54*, 1137-1143.

Scheier, M. F. & Carver, C. S. (1985). Optimism, coping, and health: Assessment and implications of generalized outcome expectancies. *Health Psychology, 4*(3), 219-247. Doi:10.1037//0278-6133.4.3.219.

Schou, I., Ekeberg, O., & Ruland, C. M. (2005). The mediating role of appraisal and coping in the relationship between optimism-pessimism and quality of life. *Psycho-Oncology. 14*(9), 718-727. Doi:10.1002/pon.896.

Shaya, F. T., Chirikov, V. V., Howard, D., Foster, C., Costas, J., Snitker, S., Frimpter, J., & Kucharski, K. (2014). Effect of social networks intervention in type 2 diabetes: A partial randomised study. *Journal of Epidemiol Community Health, 68*(4), 326-332.

Shively, C. A., Clarkson, T. B., Kaplan, J. R. (1989). Social deprivation and coronary artery atherosclerosis in female cynomolgus monkeys. *Atherosclerosis, 77*, 69-76.

Shonkoff, J. P., Garner, A. S., Siegel, B. S., Dobbins, M. I., Earls, M. F., Garner, A. S., Wood, D. L. (2011). The lifelong effects of early childhood adversity and toxic stress. *Pediatrics*, *129*(1), 232-246.

Sorajjakool, S., & Lamberton, H. (2004). S*pirituality, health, and wholeness: An introductory guide for health care professionals*. Routledge.

Stanton, M. E., Patterson, J. M., Levine, S. (1985). Social influences on conditioned cortisol secretion in the squirrel monkey. *Psychoneuroendocrinology, 10*, 125-134.

Sterner, W. R., & Jackson-Cherry, L. R. (2015). The influence of spirituality and religion on coping for combat-deployed military personnel. *Counseling and Values, 60*(1), 48-66. Doi:10.1002/j.2161-007X.2015.00060.x.

Süß, S. T., Olbricht, L. M., Herlitze, S., & Spoida, K. (2022). Constitutive 5-HT2C receptor knock-out facilitates fear extinction through altered activity of a dorsal raphe-bed nucleus of the stria terminalis pathway. Translational Psychiatry, 12(487). Doi:10.1038/s41398-022-02252-x.

Substance Abuse and Mental Health Services Administration (SAMHSA). (2018). *Helping children and youth who have traumatic experiences*. Retrieved from https://www.samhsa.gov/sites/default/files/brief_report_natl_childrens_mh_awareness_day.pdf.

Temple, E., Deutsch, G. K., Poldrack, R. A., Miller, S. L., Tallal, P., Merzenich, M. M., & Gabrieli, J. D. E. (2003). Neural deficits in children with dyslexia ameliorated by behavioral remediation: Evidence from functional MRI. *Proceedings of the National Academy of Sciences USA, 100*(5), 2860-2865. Doi:10.1073/pnas.0030098100.

Upenieks, L. (2021). Psychological resilience after cancer via religion/spirituality: Spiritual capital through a life course lens. *Journal for the Scientific Study of Religion*. Doi:10.1111/jssr.12765.

US Census Bureau. (2018). *Self-described religious identification of adult population*, *Census Bureau Reports*. Retrieved from https://www.census.gov/library/publications/2011/compendia/statab/131ed/population.html.

Vallurupalli, M., Lauderdale, K., Balboni, M. J., Phelps, A. C., Block, S. D., Ng, A. K., Kachnic, L. A., Vanderweele, T. J., & Balboni, T. A. (2012). The role of spirituality and religious coping in the quality of life of patients with advanced cancer receiving palliative radiation therapy. *Journal of Supportive Oncology, 10*(2), 81-87. Doi:10.1016/j.suponc.2011.09.003.
Walter, N., Nikoleizig, L., & Alfermann, D. (2019). Effects of self-talk training on competitive anxiety, self-efficacy, volitional skills, and performance: An intervention study with junior sub-elite athletes. *Sports (Basel), 7*(6), 148.

World Bank (2019). *GNI per Capita, Atlas Method (Current US$)*. Retrieved from https://data.worldbank.org/indicator/ny.gnp.pcap.cd.

World Health Organization (2012). *WHOQOL user manual*. Retrieved from https://apps.who.int/iris/handle/10665/77932.

Restored to Wholeness

> ❝ Thoughts become words, words become actions, actions become habits, habits become character, character shapes relationships, and relationships shape our quality of life. ❞

The Wholistic Health Program © is evidence based combining research, data, and more than 50 pilot participants to develop a transformational concept that improves quality of life. As popularly stated, life is relationships, the rest are just the details; every part of life is highly impacted by the quality of our relationships. This interactive workbook includes 10 guided exercises to identify and correct behaviors that scientifically impact relationships and ultimately health, using proven strategies like Cognitive Behavior Therapy, Neuroplasticity Cognitive Training, Stages of Change, and Behavior Redirection. Address trauma, coping skills, detoxing physically and mentally, establishing boundaries, emotional intelligence, positive self-talk, gratefulness, reshaping our environment and inner circles, as well as an optional spiritual health component addressing forgiveness, overcoming fear, identity, understanding and winning spiritual battles, and more. The program is easy to follow, flexible, and can be self-directed, group supported, or supported by a clinical professional. Recreate a wholistically healthy life and be restored to wholeness.

About the Author

Sheena Crawford is an advocate for wholistic health and is passionate about sharing successful nutrition and lifestyle information with those seeking a healthier life wholistically. Sheena is a certified health and wellness coach, has over a decade of professional experience ensuring high quality and evidence based programs in healthcare, has mental health first aid certification, social and behavioral research certification, and a doctorate in healthcare administration.