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Evaluating a Self-Developed Physical Wellness Self-Care Plan: A Single-Subject Design

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Abstract

Counseling is an emotionally demanding field that requires that counselors engage in effective self-care practices to lessen the risk of counselor distress, burnout, and impairment. Although there are several different types of self-care (physical, emotional, social, cognitive, and spiritual), this project starts with the very pragmatic physical type of self-care. The research question asks "can a practicing counselor demonstrate the effectiveness of self-developed physical wellness plans (exercise and nutritional plans), through reduction in body weight, resting heart rate, and blood pressure (systolic and diastolic)?" The single subject participant monitored her dependent variables daily for 41 days during baseline (phase A), then engaged in her self-developed exercise plan (utilized an online exercise wellness module based on the American College of Sports Medicine, 2006, guidelines for exercise prescription) for 28 days (phase B), then did a combination of her exercise plan with her self-developed nutritional plan (utilized an online nutritional module that contained a nutritional tracker - www.choosemyplate.gov) for an additional 28 days (phase C). The results indicated that the participant lost 12 pounds during the project, and increased her heart efficiency by 11.0% (decreased her resting heart rate from 82 to 73 beats per minute). The participant's blood pressure was in an optimal range during baseline and did not change significantly during the study.

Introduction

What do you, as a counselor, do for self-care? Are your self-care practice patterns sufficient in recharging and reenergizing you to continue to practice as a counselor? How do you know that your self-care practices are effective? Have you ever self-designed and

evaluated a self-care plan for yourself? If the answers to the above questions are respectively “*not much*,” “*no*,” “*don’t know*,” and “*no*,” this study is for you.

Counselors need to take care of themselves because the profession of counseling is emotionally demanding and requires counselors to be fully present to focus completely on clients in order to best meet the clients’ needs. Counselors need self-care practice patterns that can be implemented when at work (between sessions) as well as outside of work (Norcross & Guy, 2007). Counselors need self-care to avoid the professional hazards of counselor distress, burnout, and impairment (Remley & Herlihy, 2010). Self-care is encouraged in the American Counseling Association *Code of Ethics* (2005). However, many counselors are so other-focused in addressing the human needs of others that they end up putting their own needs last, which results in counselors practicing without the safety net of recharging and reenergizing self-care practices.

The purpose of this study was to have a practicing counselor, with insufficient self-care practices, self-develop physical wellness plans (exercise and nutritional plans) and then evaluate those self-developed physical wellness plans through a single-subject design with the dependent variables of body mass (weight), resting heart rate (heart efficiency), and blood pressure (systolic and diastolic). The rationale for the physical wellness plans (exercise and nutrition) was that both are required components of physical wellness in the Indivisible Self Model of Wellness (Myers & Sweeney, 2004). The rationales for the three dependent variables were weight is a good overall indicator of physical health; resting heart rate is a good overall indicator of cardiovascular fitness (the more efficient the heart, the less beats per minute needed to circulate blood in the body; Mayo Clinic, 2013); and blood pressure is a good overall indicator of cardiovascular health (consistent physical exercise makes the heart work more efficiently which decreases the pressure on the walls of the arteries; Mayo Clinic, 2012).

Statement of the Problem

Wellness

Wellness is one of the fundamental principles of the counseling profession which is in contrast to the many allied helping professions (e.g., psychiatry and clinical psychology) that follow the more dominant medical (illness) model. Wellness not only plays a central role in treatment planning with clients, it also requires counselors to be excellent role models of personal self-care practices. Wellness is defined as a “way of life orientated toward health and well-being in which body, mind, and spirit are integrated by the individual to live life more fully within the human and natural community” (Myers, Sweeney, & Witmer, 2000, p.252).

Myers and Sweeney (2004) developed an evidence-based model of wellness called the Indivisible Self Model of Wellness that includes five domains of individual wellness (creative domain – thinking, emotions, control, work, and positive humor; coping domain – leisure, stress management, self-worth, and realistic beliefs; essential domain – spirituality, gender identity, cultural identity, and self-care; physical domain – exercise, and nutrition; social domain – friendship, and love) and identified 17 components of wellness.

Self Care

Even though self-care is considered just one of the 17 components of wellness in the Indivisible Self Model of Wellness (Myers & Sweeney, 2004), it is often considered the most comprehensive wellness component and is synonymous with overall wellness. “Counselors engage in self-care activities to maintain and promote their emotional, physical, mental, and spiritual well-being to best meet their professional responsibilities” (ACA, 2005, Section C Introduction, p. 9).

Self-care relates to concern and attention to one’s well-being in all its dimensions. Choosing to develop safety habits, including practicing preventive medical and dental care, wearing seat belts, and avoiding harming substances including those in the environment, improves quality of life and extends longevity. The absence of self-care to whatever extent circumstances permit may be considered a sign of essential discouragement with life. (Ivey, Ivey, Myers, & Sweeney, 2005, p. 52)

There are many different types of self-care wellness that include cognitive self-care (e.g., creative thinking, intervening in problematic thinking patterns – dichotomous thinking), emotional self-care (e.g., intervening in problematic emotional functioning patterns), social self-care (e.g., seeking and maintaining supportive relationships and dealing with relational conflicts), spiritual self-care (e.g., practices that are consistent with life values that promote hope, optimism, and personal meaning), and physical self-care (e.g., developing physical functioning patterns that promote health and well-being such as development of serious leisure hobbies, consistent exercise, and healthy nutrition plans). Wozny (2012) discussed the importance of developing counselor’s casual leisure (immediately pleasurable activities that are not associated with one’s adult identity) into serious leisure pursuits (activities to which one tends to lose track of time and are associated with one’s adult identity) as a vital form of ongoing counselor self-care. Wozny provided a leisure wellness exercise for counselors to develop their casual leisure into serious leisure that included: self-assessment of past leisure activities/hobbies; self-assessment of current leisure activities/hobbies; exposure to new leisure activities/hobbies; and formulation of future personal plan for serious leisure.

Counselors that choose to overlook the importance of personal self-care are the counselors most at risk of advancing from counselor distress to burnout and eventually to counselor impairment. Remley and Herlihy (2010) conceptualized the concepts of counselor distress, burnout, and impairment as a continuum of counseling functioning difficulties from, respectively, mild to most severe.

Distressed counselors may experience anxious and depressed moods, somatic complaints, lowered self-esteem, and feelings of helplessness, but they are not necessarily impaired in their professional functioning. They know at some subjective level that something is wrong and distress is usually a transitory and temporary condition.

When distress remains unalleviated, however, it can lead to burnout. Burned out counselors, exhausted and depleted, have little energy left for their clients. They tend to manifest negative attitudes toward self and work. Burnout is not so much a state or condition as a process that, if not corrected, can lead to impairment.” (Remley & Herlihy, 2010, p. 176)

Counselor impairment is when day-to-day clinical functioning (counselor competency) with clients is diminished to the point that clients are at risk of being harmed in counseling (Remley & Herlihy, 2010). The counseling profession is very concerned with the issue of counselor impairment and has emphasized the saliency of counselor impairment in the *ACA Code of Ethics* (2005) Ethical Standard C.2.g (Counselor Impairment).

Counselors are alert to the signs of impairment from their own physical, mental, or emotional problems and refrain from offering or providing professional services when such impairment is likely to harm a client or others. They seek assistance for problems that reach the level of professional impairment, and, if necessary, they limit, suspend, or terminate their professional responsibilities until such a time it is determined that they may safely resume their work.” (ACA, 2005, Ethical Standard C.2.g, p. 9)

Physical Wellness—Exercise and Nutrition: Issue of Obesity in United States and Mississippi

Obesity is a critical health problem in the United States. The Centers for Disease Control (CDC; 2011) defines an individual as obese if that person has a body mass index (BMI) greater than 30. Ogden, Carroll, McDowell, and Flegal (2007) found that 34% of American adults over age 20 are obese and that includes 33.3% of adult men and 35.3% of adult women. The current obesity rates in the United States are still significantly higher than the Healthy People 2010 national health objectives (U.S Department of Health and Human Services, 2000) that aimed to reduce obesity rates to less than 15% of adults. However, some states are significantly closer to the national health objectives for obesity than other states. The overall average state obesity rate in the United States for 2007 (which includes children, adolescents, and adults) is 25.6% with a range from a low of 18.7% (Colorado) to a high of 32.0% (Mississippi; Centers for Disease Control, 2008). Thus, states with the highest rates of obesity will benefit most from physical wellness programming (diet and exercise intervention programs).

In order to begin to address the high rate of obesity in Mississippi, it is important to focus intervention programs on the subpopulations with the highest obesity rates. Nationally, the rate of adult obesity varies considerably by age and race/ethnicity. For both men and women, middle-aged adults (aged 40-59 years) had the highest reported rates of obesity (men – 40.0%; women – 41%). Comparatively, young adults (aged 20-39 years) and older adults (60 years and older) reported lower rates of obesity than middle-aged adults (young adults – 28.0% of men and 30.5% of women; older adults – 32.0% of men and 30.5% of women; Ogden et al., 2007). For women, obesity rates also vary considerably by race/ethnicity. Among middle-aged women (aged 40-59 years), non-Hispanic black and Mexican-American women reported the highest obesity rates (53% and 51% respectively) compared to 39% of non-Hispanic white women (Ogden et al., 2007). Thus, in Mississippi, physical wellness programming that targets middle-aged (aged 40-59 years) adults, and non-Hispanic black and/or Mexican-American women would begin to help address the issue of obesity.

To help address the issue of obesity in Mississippi and the need for counselors to develop conducive self-care practice patterns, Wozny and Porter (2009) developed a physical wellness self-monitoring exercise for practicing counselors and counselors-in-training. Wozny and Porter encouraged counselors to enter their daily nutritional intake and physical activities into a government Web site (www.mypyramidtracker.gov), which is the predecessor of the current Supertracker (www.choosemyplate.gov), to provide the data necessary for single-subject design (ABC design: A phase – Baseline; B phase – Intervention I; C phase – Intervention II) to evaluate their self-developed wellness intervention plans (exercise and/or nutritional plans). However, Wozny and Porter identified that counselors experienced difficulties in self-developing viable exercise programs for themselves in the physical wellness self-monitoring project. This issue was addressed when Wozny and Wozny (2011) synthesized the American College of Sports Medicine (ACSM) guidelines for exercise prescription that helped define the program parameters necessary in developing cardio-respiratory, resistance-based, and flexibility exercise programs.

Research Question

Can a practicing counselor demonstrate the effectiveness of self-developed physical wellness plans (exercise and nutritional plans) through reduction in body weight, resting heart rate, and blood pressure (systolic and diastolic)?

Methods

Research Design: Single Subject Design

The research design used in this research study is a single subject design (ABC design). Baseline phase (phase A) measured the participant's daily weight, resting heart rate (HR), and blood pressure (systolic and diastolic blood pressure) over a 41 day period. The intervention I phase (phase B – exercise plan only) measured the participant's daily weight, resting heart rate (HR), and blood pressure (systolic and diastolic blood pressure) over a 28 day period. The intervention II phase (phase C – exercise plan + nutritional plan) measured the participant's daily weight, resting heart rate (HR), and blood pressure (systolic and diastolic blood pressure) over a 28 day period.

The rationale for the use of a single-subject design (ABC design) in this study was that it was necessary to evaluate a single participant's individualized self-developed physical wellness plans (exercise and nutritional plans) based on the two physical wellness modules (exercise and nutrition). Experimental group designs would be inappropriate to evaluate the practical applications of the physical wellness modules (exercise and nutrition) because both modules promote effective parameters for individuals to self-develop their own exercise and nutritional intervention plans.

Participant

The research participant is a middle-aged African-American female student in the Education Specialist Program seeking an Education Specialist degree in School Counseling at Mississippi State University-Meridian. The participant is a practicing counselor in Meridian, Mississippi. The research participant's BMI of 39.8 indicated that she was severely obese (beginning weight at 232 pounds at a height of 64 inches). The

research participant lacked a current exercise plan and she described her diet as unhealthy. The research participant also stated that due to her health, she currently experienced difficulties with regular headaches and getting to sleep and staying asleep at night. She indicated that she was often very tired and felt low in energy. The participant consulted with the family physician and her doctor indicated that that she needed to exercise and improve her diet. The participant consulted again with her family physician when she developed her exercise and nutritional plans to ensure that the plans were appropriate for her health.

Setting

The original setting for the study's wellness modules (www.meridian.msstate.edu/complete) is the Mississippi State University-Meridian Campus whereby the online wellness modules, based on the Indivisible Self Model of Wellness (Myers & Sweeney, 2004), were developed to meet the SAMHSA Campus Suicide Prevention Grant goal of increasing campus wellness as a protective factor against the risk of suicide on our college campus. In all, 17 wellness modules were developed that matched the 17 identified components of wellness in the Indivisible Self Model of Wellness.

In the wellness module – exercise, the module is based on the American College of Sports Medicine (ACSM) Guidelines for Exercise Prescription in the areas of cardio-respiratory exercise programs, resistance exercise programs, and flexibility exercise programs (ACSM, 2006). These exercise guidelines have been summarized into exercise program parameters that would help individuals safely develop an exercise program (cardio, resistance, and flexibility) based on level of physical fitness (beginner, intermediate, and advanced).

In the wellness module – nutrition, the module is based on federal government guidelines on healthy eating for Americans and contains information on balanced nutrition, examples of appropriate foods for each food group, as well as detailed information on appropriate foods to address deviations in detailed nutritional analysis (based on Supertracker). The nutritional module also discusses problematic eating habits (e.g., foods high in sugar, sodium, saturated fat, caffeine, etc).

Instruments

The instruments used in this study include the participant's personal weight scale and a home heart rate and blood pressure monitor. The participant weighed herself using her personal home weight scale at the same time each morning upon waking prior to getting dressed and having breakfast. The participant measured her resting heart rate (HR) using her personal heart rate wrist monitor at the same time each morning upon waking after weighing herself. The participant measured her systolic and diastolic blood pressure using a home blood pressure wrist monitor at the same time each morning upon waking after measuring her weight and her resting blood pressure.

The participant recorded in a personal journal her daily weight, resting heart rate, and blood pressure each day throughout the baseline phase (41 days), intervention I phase (28 days), and intervention II phases (28 days).

Procedures

The participant recorded in a personal journal her daily weight, resting heart rate, and blood pressure each day (see instruments) throughout the baseline phase (41 days), intervention I phase (28 days), and intervention II phase (28 days).

In the baseline phase (Phase A), the participant reviewed the physical wellness - exercise module (www.meridian.msstate.edu/complete) and self-developed her own exercise plan that was viable for her health status (beginner level of exercise). She was instructed not to commence any new exercise and/or nutritional plans during the baseline period (41 days).

In the intervention I phase (Phase B - exercise plan only), the participant was to implement her self-developed exercise plan (see Appendix A - Interventions) each day for 28 days. The participant maintained a treatment (intervention) fidelity journal to establish the degree that the participant followed her self-developed exercise plan (see Internal Validity Threats – Treatment Fidelity). The participant was instructed to review the physical wellness - nutrition module (www.meridian.msstate.edu/complete) and self-develop her own nutritional plan that was viable for her health status. The participant indicated that she wanted to enter her daily dietary intake in Supertracker (see Internal Validity Threats – History), though was instructed to not make any changes to her nutritional plan until intervention II phase.

In the intervention II phase (Phase C - exercise plan + nutritional plan), the participant was to continue to implement her self-developed exercise plan (see Appendix A - Interventions) and also implement her self-developed nutritional plan each day for another 28 days. The participant maintained a treatment (intervention) fidelity journal to establish the degree that the participant followed her self-developed exercise and nutritional plans (see Internal Validity Threats – Treatment Fidelity). The participant continued to enter her daily dietary intake in Supertracker (see Internal Validity Threats – History) during the intervention II phase (Phase C).

Internal Validity Threats

The most salient internal validity threats associated with this single-subject research study includes instrumentation, history, mortality, and treatment (intervention) fidelity.

Instrumentation is an internal validity threat because the outcome of a research study can be due to instruments that lack validity and/or reliability rather than the interventions being tested in a study. The instruments used in this study included a personal weight scale, wrist heart rate monitor, and wrist blood pressure monitor. All three instruments (weight scale, heart rate monitor, and blood pressure monitor) are valid and reliable methods of measuring weight, resting heart rate, and blood pressure (systolic and diastolic blood pressure). The participant weighed herself using her personal home weight scale (always used the same scale) at the same time each morning upon waking prior to getting dressed and having breakfast. The participant always ensured that her weight scale was in good working order through the project. The participant measured her resting heart rate (HR) using her personal heart rate wrist monitor at the same time each morning upon waking after weighing herself. The participant measured her systolic and diastolic blood pressure using a home blood pressure wrist monitor at the same time each morning upon waking after measuring her weight and her resting heart

rate. With wrist blood pressure monitors, it is important to ensure that instructions are followed such as measuring when the arm (wrist cuff) is at the same height as the heart.

History is an internal validity threat because the outcome of a research study can be due to an intervention in the natural environment of the participant that operates concurrently with the study's intervention and creates a confound of which intervention accounted for the study's outcome. In the nutrition wellness module, where the participant self-developed her nutritional plan, there was a link to the Web site (www.choosemyplate.gov) that contained the federal government nutritional tracker (Supertracker) that allows individuals to enter their daily nutritional intake in order to learn whether one's diet is balanced in terms of food groups, detailed nutritional analysis (e.g., calories, sodium, saturated fat, sugar, vitamins, and minerals), and recommendations for changing dietary intake. The participant in our study entered her daily nutritional intake throughout the baseline, intervention I (exercise plan only), and intervention II (exercise + nutritional plans) phases of the study. However, the participant only made changes to her diet during the intervention II phase. History is an internal validity threat in this study.

Mortality is an internal validity threat because the outcome of a research study can be adversely impact by participant dropout. In a single-subject design, mortality is a major potential internal validity threat because there is only one participant in the study. To encourage the participant to remain in the study the participant received two \$20 gift cards for participating in the project. However, the participant would have received the gift cards if she had chosen to dropout because there were no consequences associated with voluntary dropout in the study.

Treatment (intervention) fidelity is an internal validity threat because the outcome of a research study can be confounded if the study's intervention is not implemented as intended, which makes it difficult to determine the nature of the study's actual intervention. Thus, it is important in this study to be sure that the interventions (participant's self-developed exercise and nutritional plans) are implemented as originally planned. The participant maintained an intervention fidelity journal and each day checked whether the exercise and nutritional plans were followed as originally planned and made note of any deviations to the physical wellness plans. The participant did note two days were she indicated she was not feeling well and did not exercise those days and did not follow her nutritional plans. However, the vast majority of the time during the intervention I (exercise only) and intervention II (exercise + nutritional plans) phases, the participant demonstrated high treatment (intervention) fidelity.

External Validity Threat

The main limitation of this study is the lack of generalizability of the results (external validity threat) due to the sample size (single participant) associated with the chosen research design (single-subject design).

Results

The baseline phase (phase A) measured the participant's daily weight, resting heart rate (HR), and blood pressure (systolic and diastolic blood pressure) over a 41 day period. The baseline phase (phase A) participant's average weight was 234.3 pounds. The

baseline phase (phase A) participant's resting heart rate (HR) was 88.2 beats per minute. The baseline phase (phase A) participant's blood pressure was 113.8 (systolic blood pressure) over 83.3 (diastolic blood pressure) or 113.8/83.3.

The intervention I phase (phase B – exercise plan only) measured the participant's daily weight, resting heart rate (HR), and blood pressure (systolic and diastolic blood pressure) over a 28 day period. The intervention I phase (phase B – exercise plan only) participant's average weight was 233.6 pounds. The intervention I phase (phase B – exercise plan only) participant's resting heart rate (HR) was 84.7 beats per minute. The intervention I phase (phase B – exercise plan only) participant's blood pressure was 115.1 (systolic blood pressure) over 86.1 (diastolic blood pressure) or 115.1/86.1.

The intervention II phase (phase C – exercise plan + nutritional plan) measured the participant's daily weight, resting heart rate (HR), and blood pressure (systolic and diastolic blood pressure) over a 28 day period. The intervention II phase (phase C – exercise plan + nutritional plan) participant's average weight was 226.9 pounds. The intervention II phase (phase C – exercise plan + nutritional plan) participant's resting heart rate (HR) was 75.9 beats per minute. The intervention II phase (phase C – exercise plan + nutritional plan) participant's blood pressure was 109.7 (systolic blood pressure) over 80.9 (diastolic blood pressure) or 109.7/80.9.

Discussion

The key part of a self-care plan is that it is a self-developed plan that is individualized to the needs of that individual. This study was not designed to encourage counselors to follow one particular type of exercise and nutritional plan (physical wellness) but to demonstrate that a self-developed plan (within the acceptable parameters presented in the physical wellness modules at www.meridian.msstate.edu/complete) can be implemented and evaluated for its effectiveness.

The participant's self-developed exercise and nutritional plans (physical wellness) were implemented and found to be effective in decreasing body mass (weight), increasing heart efficiency (resting heart rate), and decreasing blood pressure (systolic and diastolic blood pressure).

In terms of body mass (weight), from baseline phase (A) to intervention I phase (B – exercise plan only) the participant lost just 0.3% of her body weight. However, from intervention I phase (B – exercise only) to intervention II phase (C - exercise + nutrition plans) the participant lost 2.9% of her body weight. From baseline phase (A) to intervention II phase (C), the participant lost 3.2% of her body weight. The participant started the study at 232 pounds with a body mass index (BMI) of 39.8 (obese) and ended the study after 97 days at 220 pounds with a BMI of 37.8 (obese) for an overall reduction in body mass (weight) of 5.2%. The participant was successful in significantly decreasing body mass (weight) in just 8 weeks of intervention (4 weeks of exercise only and 4 weeks of exercise and nutritional plans).

In terms of heart efficiency (resting heart rate), from baseline phase (A) to intervention I phase (B – exercise plan only) the participant's resting heart rate decreased by 4.0%. However, from intervention I phase (B – exercise only) to intervention II phase (C - exercise + nutrition plans) the participant's resting heart rate decreased 10.3%. From baseline phase (A) to intervention II phase (C), the participant's resting heart rate

decreased 13.9%. The participant started the study with a resting heart rate of 82 and ended the study after 97 days with a resting heart rate of 73 for an overall reduction in resting heart rate of 11.0% which indicates a significant increase in heart efficiency.

In terms of blood pressure (systolic and diastolic blood pressure), from baseline phase (A) to intervention I phase (B – exercise plan only) the participant's blood pressure increased by 1.2% (systolic) and 3.4% (diastolic). However, from intervention I phase (B – exercise only) to intervention II phase (C - exercise + nutrition plans) the participant's blood pressure decreased 4.7% (systolic) and 6.1% (diastolic). From baseline phase (A) to intervention II phase (C), the participant's blood pressure decreased 3.5% (systolic) and 2.9% (diastolic). The participant started the study with a blood pressure of 109/80 (systolic/diastolic) and ended the study after 97 days with a blood pressure of 103/80 (systolic/diastolic) for an overall reduction in systolic blood pressure of 5.5% and no change in diastolic blood pressure. The participant's beginning blood pressure (109/80) was within a healthy range for blood pressure (below 120/80 – www.nhlbi.nih.gov/health/health-topics/topics/hbp/) and the participant's blood pressure remained within the healthy range throughout the study and at the end of the study.

Anecdotally, the participant indicated that the physical wellness study had some very positive effects on her sleep patterns, energy level, and occurrence of somatic complaints, in particular, headaches. Prior to the study, the participant experienced significant sleep disturbances to the point that she reported sleeping just a couple of hours per night which influenced her to have low energy for her demands of daily living. In addition, she indicated that she was experiencing significant recurrent headaches. After the study, the participant reported improved sleeping patterns and feeling well rested, which helped her to have the energy needed to function. The participant also indicated that the frequent headaches had subsided and attributed it to exercising more and eating healthier.

The participant's anecdotal findings are consistent with a basic premise of the Indivisible Self Model of Wellness (Myers & Sweeney, 2004), whereby change in any one component (exercise and nutrition) can have a positive ripple effect on other components of wellness (self-care, stress management, emotions, work, etc.). Furthermore, by the participant maintaining the new physical wellness patterns (plans) in her life, the occupational risks of counselor distress, burnout, and impairment are more manageable as well.

Thus, every counselor must, at some point, develop his/her own self-care plan that will protect him/her from the risks of counselor distress, burnout, and impairment. The self-care plan need not be similar to what other counselors choose to implement for self-care, but the counselor does need to choose a self-care plan that is most effective for his or her needs. Moreover, the counselor needs to evaluate the self-care plan or at the very least implement best practices for self-care plans. This study highlights how a counselor can utilize the ACSM guidelines on exercise prescription (Wozny & Wozny, 2011) as well as U.S. Federal guidelines on healthy eating (www.choosemyplate.gov) to self-develop exercise and nutritional physical wellness plans as one part of a comprehensive self-care plan and evaluate the effectiveness of the physical wellness self-care plans. Our counseling clients deserve counselors that are fine role models of self-care and wellness.

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Note: This paper is part of the annual VISTAS project sponsored by the American Counseling Association. Find more information on the project at: http://counselingoutfitters.com/vistas/VISTAS_Home.htm

Appendix A

Intervention Plans

Exercise Plan

Basic Resistance Training Program (3 days/week)

Exercise	Muscle	Training Volume
Standing Lunge	Hip/Buttocks	5-8 reps (1-3 sets)
Squats	Legs/Thighs	5-8 reps (1-3 sets)
Bicycle Crunch	Abdomen	5-8 reps (1-3 sets)
Weighted Step-Ups (Stool)	Hip/Buttocks	5-8 reps (1-3 sets)
Triceps Extensions	Arms-Triceps	5-8 reps (1-3 sets)

Cardio Exercise Plan (Daily)

Brisk Walking Daily (20 Minutes each day)

Nutrition Plan

The participant's self-developed 2000 calorie nutritional plan included the following components:

- Grains (6 ounces per day)
- Whole Grains (3 ounces per day)
- Vegetables (2 ½ cups per day)
- Fruits (2 cups per day)
- Dairy (3 cups per day)
- Protein (5 ½ ounces per day)
- Oils (6 tsp. per day)

The participant developed a daily diet as a guide on what she could eat. Breakfast included whole grain cereal, 2% milk, and a banana. Lunch consisted of a salad and baked chicken, green vegetables, sweet tea, and water. Dinner included steamed vegetables, dinner rolls, and either baked chicken, steak, or fish. Snacks included nuts, oranges, apples, pineapple, popcorn, or grapes. The participant also allowed herself one soda per day though did ensure that she drank eight glasses of water daily.