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Counseling Psychologists and Behavioral Health: Promoting Mental and Physical Health Outcomes Ψ

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Abstract

On the occasion of the 50th Anniversary of *The Counseling Psychologist*, we reflect on the many contributions that counseling psychologists have made and are poised to make in the areas of behavioral health and behavioral health care. We note that psychologists' engagement in health promotion and prevention of behavioral, mental, and emotional disorders is consistent with counseling psychology values. We provide a concise review of theories that are widely applied in behavioral health contexts and discuss ways in which counseling psychologists may apply these theories to help ameliorate health disparities, empower communities to take control of their own health, and promote social justice. In addition, we highlight the need to create interdisciplinary partnerships to conduct culturally sensitive research on the bi-directional relationship between mental health and physical health. The article ends with wide-ranging implications and recommendations for theory development, research, training, practice, and advocacy.

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Counseling psychologists, like other health professionals, are becoming increasingly involved in health promotion and the prevention of behavioral, mental, and emotional disorders (Nilsson, Berkel, & Chong, 2019 [this issue]). Health professionals are also becoming increasingly aware that research, practice, training, and advocacy related to health promotion and prevention are ideally interdisciplinary and responsive to the bidirectional relationship between mental health and physical health (Office of Disease Prevention and Health Promotion, 2017). Notably, health promotion and prevention of behavioral, mental, and emotional disorders are also important aspects of behavioral health, particularly as integrated into primary health care. Behavioral health has been defined as "an umbrella term for care that addresses any behavioral problems bearing on health, including mental health and substance abuse conditions, stress-linked physical symptoms, patient activation, and health behaviors" (Peek & the National Integration Academy Council, 2013, p. 9). When it is integrated into primary health care settings, behavioral health is commonly referred to as behavioral health care. Furthermore, when behavioral health care is systematically implemented by interdisciplinary teams (which increasingly have counseling psychologists in their ranks), includes patients and their families, and is patient centered, this care is often called integrated care.

On the occasion of the 50th Anniversary of *The Counseling Psychologist* (*TCP*), it seems fitting to focus on counseling psychology in the context of the aforementioned interrelated areas of health promotion, prevention, behavioral health, and behavioral health care. Despite their promise as an occupational context for counseling psychologists, historically behavioral health and behavioral health care have not been major foci within the field of counseling psychology or within *TCP*. To address this gap, the current issue of *TCP* focuses on counseling psychologists' roles within behavioral health and behavioral health care. In this article, we provide an introduction to theories that counseling psychologists can draw from to engage in these health-focused areas; additionally, we identify research related to these theories as well as the strengths and weaknesses of the reviewed theories. We also highlight the bidirectional relationship between physical health and mental health indicated by theses theories and related research. Additionally, we share implications for culturally sensitive theory development, research, training, practice and advocacy related to health promotion and prevention within the areas of behavioral health and behavioral health care. Our article is followed

by a Major Contribution that addresses, specifically, counseling psychologists' promise as members of integrative health care teams (Berkel et al., 2019 [this issue]; Boland, Juntunen, Kim, Adams, & Navarro, 2019 [this issue]; Nilsson et al., 2019; Perrin & Elliott, 2019 [this issue]).

As noted by former American Psychological Association (APA) president Suzanne Bennett Johnson (2012), advancing health is an interdisciplinary task that will increasingly require psychology's involvement. Consistent with her observation, counseling psychologists have become more engaged in shaping and delivering health care services in recent years (Lichtenberg, Hutman, & Goodyear, 2018). Notably, counseling psychology training programs have reported a robust interest in health psychology, recognizing a need to develop structured curricula within this area (Boland et al., 2019; Raque-Bogdan, Torrey, Lewis, & Borges, 2013). The current emphasis on health promotion and prevention is likely to continue in the future, as higher numbers of counseling psychology students and interns choose to do their practica and internships in health care settings (Association of Psychology Postdoctoral and Internship Centers, 2018).

The focus on health promotion and prevention as well on behavioral health can be traced to the time in history when communicable diseases gave way to chronic diseases, creating a need to address the modifiable factors in the occurrence of the latter diseases (Catalano et al., 2012; Schmidt, 2016). The shift toward prevention in the field of counseling psychology took hold at the turn of the 21st century, when there was a change in focus from conventional remediation models to preventive approaches—seen as "a fascinating paradigm shift" (Newmeyer, 2006).

More recently, the important role of prevention in improving health outcomes was highlighted in the Patient Protection and Affordable Care Act (2010), which called for the creation of the National Prevention Council. In turn, the Council developed the U.S. National Prevention Strategy (U.S. National Prevention Council, 2011). This document called for a change in focus from sickness and disease to wellness and prevention. In addition, it highlighted the need to promote mental health and to integrate mental health into various health care delivery contexts, such as the VA. Consistent with these national trends, the recently published counseling psychology Model Training Program includes prevention as one of the field's core values, noting that students should be educated on socially and culturally relevant prevention methods along with their implications for research, practice, and social advocacy (Scheel, Stabb, Cohn, Duan, & Sauer, 2018). Thus, through engaging in prevention to promote physical health, counseling psychologists are affirming their intent to address precursors to physical health problems, avoiding a later need for remediation of these problems.

Work in behavioral health, which includes a major focus on behavior changes for physical and mental health promotion and recognizes the bidirectional relationship between mental and physical health, also draws on counseling psychologists' strengths in assessment and multicultural counseling—the latter representing an area that has traditionally not been a core aspect of training in clinical, health, and clinical health psychology. Having extensive training in multicultural counseling is particularly valued at VA Medical Centers and primary care clinics, both of which tend to serve racially and ethnically diverse patients.

The promotion of mental health and well-being across the lifespan is another hallmark of counseling psychology that is relevant to behavioral health and behavioral health care. Counseling psychologists strive to empower individuals at each stage of life with knowledge, skills, behaviors, perspectives, and resources to cope effectively with life challenges at that developmental stage (Ivey, 1986). In turn, these life stages often come with stage-specific adjustment stressors and other mental health challenges that contribute to individuals' engagement in health risk behaviors (e.g., smoking) and promote physical health problems (e.g., hypertension). Thus, counseling psychologists are particularly well-poised to identify developmentally related factors, including health risk behaviors and health promotion behaviors, that influence physical and mental health outcomes.

Counseling psychologists have been trained, as well, to value the role of education in producing behavior changes. Psychoeducational interventions have been shown to improve mental health outcomes (Lucksted, McFarlane, Downing, & Dixon, 2012; Schiffman et al., 2015). Professionals in the field of counseling psychology understand the need to tailor information to various audiences (Reese & Vera, 2007) and to attend to multicultural and developmental issues in this process (Buki, Salazar, & Pitton, 2009), both of which enhance outcomes of psychoeducational interventions (Bernal, Jiménez-Chafey, & Domenech Rodríguez, 2009; Noar, Benac, & Harris, 2007).

Given the fit between counseling psychologists' values and training, and the current impetus for the provision of behavioral health care and integrated health care, counseling psychologists can seize an important opportunity to contribute to public health and well-being. Combining psychological and behavioral health services with primary care services leads to lower costs and higher quality of care, ultimately saving lives (National Institute of Mental Health, 2017). When these combined services are culturally sensitive, they have a higher likelihood of reducing the costly health disparities that have a disproportionately negative effect on racial and ethnic minorities, gender and sexual minorities, groups with low incomes, and the medically underserved (Buki, 2007; Buki & Selem, 2012; Goldberg, Kuvalanka, Budge, Benz, & Smith, 2019; Matsuno &

Israel, 2018; Tucker, Williams, Roncoroni, & Heesacker, 2017). Thus, counseling psychologists' work in medical settings is aligned with the social justice cornerstone of counseling psychology, which implicitly includes health and health care justice.

Although chronic diseases are prevalent in the United States, accounting for 90% of health care costs, only 1% of the national budget was allocated for prevention in 2019 (American Public Health Association, 2019). Thus, given the current trend toward the provision of integrative health care services, and given counseling psychologists' potential to make significant contributions to prevention efforts, in this article we focus on the foundational theories and models that counseling psychologists can use as they engage in this work. Specifically, we present theories and models drawn from the fields of behavioral health and public health, note their strengths and shortcomings in helping conceptualize patients' needs, and discuss their applicability and fit with the skills and perspectives of counseling psychologists. We also call attention to the relationship between mental and physical health, as indicated in the theories and models, and in related research. Lastly, we present implications for future research, practice, training, and advocacy. Throughout the article, we focus on ways to promote physical health and reduce health disparities in racial, ethnic, and sexual minorities, as well as other socially disadvantaged groups or communities disproportionally affected by health disparities.

Foundational Theories in Behavioral Health

In their training, counseling psychologists typically have significant exposure to theories that are widely applied in behavioral health contexts, such as cognitive behavioral theory (Beck, 1976) and social learning theory (Bandura, 1971, 1985). In this section, we review the application of social learning theory in a behavioral health context and extend the array of theories to which counseling psychologists are exposed. We first present theories and/or models that help conceptualize an individual's readiness to engage in the process of behavioral change (the transtheoretical model) and to adhere to prevention behaviors (the health beliefs model). Next, we present theories that aim to explain factors that contribute to maintaining health promoting behaviors (social cognitive theory, theory of planned behavior, and health self-empowerment theory), as well as a theory of relapse prevention. We conclude the section by presenting a systemic model that conceptualizes a patients' directly controllable behavior in the health care context as largely influenced by the relationship between the patient and the health professional (the patient-centered culturally sensitive health care model), as well as two wellness models that conceptualize patients from a holistic

perspective (the wheel of wellness and community wellness model). For each of the theories and models presented, we note strengths and limitations, with a special focus on ways in which counseling psychologists can leverage their strengths to overcome the limitations. To illustrate these theories and models, we present the case of Lucía, a 58-year-old Latina immigrant woman with limited access to health care referred by her primary care physician for routine breast cancer screening. Lucía is ambivalent about getting a mammogram, noted she is unsure of her ability to communicate clearly with health care providers and understand their instructions, feels intimidated by the complexities of navigating the U.S. health care system, and lives far from a screening facility. We use the theories and models discussed to conceptualize her journey of health promotion and prevention.

Transtheoretical Model (TTM; Prochaska & DiClemente, 1983; Prochaska & Velicer, 1997)

TTM posits that people do not decide to make lasting changes quickly and decisively; rather, individuals engage in a process of transitional change that depends on their decision-making abilities and attitudes (Prochaska & DiClemente, 1983). The model proposes the existence of six stages of change: precontemplation, contemplation, preparation, action, maintenance, and termination (Prochaska & Velicer, 1997). During the *precontemplation* stage, an individual lacks intention to make a behavioral change as a result of failed previous attempts or of a lack of knowledge. *Contemplation* occurs when an individual considers behavioral change yet maintains a sense of ambivalence about making the change. *Preparation* involves having the needed commitment and engaging in the required planning to make a change within the next 30 days. Preparation transforms into *action* when the behavioral change is apparent for six months or less. *Maintenance* is when the change continues for more than six months. *Termination* is an extension of the maintenance stage and reflects complete self-efficacy and an "automatic" tendency to engage in the behavior.

TTM is often applied to health-related behaviors such as smoking cessation, physical activity, and eating habits. For example, researchers have found that smoking cessation involves various phases (Pbert, Jolicoeur, Haskins, & Ockene, 2018). After committing to behavioral change, patients can benefit from a motivation-building phase in which clinicians build rapport, assess willingness and confidence in quitting, and use motivational interviewing techniques (Pbert et al., 2018). Across populations, retention in psychotherapy and behavior change programs have been strongly influenced by (a) using interventions that are consistent with the client's stage of

change, and (b) tailoring treatment to meet a client's changing needs (Prochaska, DiClemente, Velicer, & Rossi, 1993).

As demonstrated through our case example, Lucía's commitment to seeking routine breast cancer screening is a process of transitional change. Counseling psychologists could assess Lucía's current stage of change and corresponding needs, followed by guiding Lucía in making the desired behavioral change (i.e., obtaining a mammogram). For instance, counseling psychologists could provide psychoeducation during the precontemplation stage by augmenting her current beliefs with factual information about the importance of early detection. During the contemplation stage, motivational interviewing techniques may be especially helpful in resolving Lucía's sense of ambivalence. As Lucía enters the preparation stage and prepares for action, counseling psychologists could process her expectations of the U.S. health care system and help her navigate any logistical concerns or structural barriers. In working with Lucía, counseling psychologists could continue tailoring treatment during the maintenance stage to increase her self-efficacy within the health care system and other contexts.

Although knowledge of the stages of change and related motivators may be very useful for effective treatment, the TTM also has important limitations. Because TTM is focused on an individual's decision-making process, it does not acknowledge ways in which external factors, such as social and cultural factors, affect an individual's ability to change (Janevic & Connell, 2018; Prochaska & Velicer, 1997). It also assumes there are discrete stages of behavioral change, although change is usually less clear and linear (Janevic & Connell, 2018). Counseling psychologists may contribute by addressing an individual's barriers to attempting behavioral change, especially in those cases where patients recognize their level of risk as well as benefits of the desired behavior. Motivational interviewing may be especially useful to help bring about change in these cases, as it is designed to address instances in which the client feels ambivalence about changing. Taking a directive stance, the practitioner helps motivate the client to resolve the ambivalence and assume responsibility for the change (Hettema, Steele, & Miller, 2005).

Health Belief Model (HBM; Becker, 1974; Becker & Maiman, 1975)

The HBM was developed to understand factors that contribute to low adherence to preventive behaviors, especially those associated with asymptomatic disease such as cancer screening tests (e.g., mammograms). This model posits that behaviors are influenced by the perceived susceptibility and severity of the disease or condition, perceived benefits of and barriers to engaging in

the behavior, and cues to action (Becker, 1974; Rosenstock, 1974). According to this model, demographic, personal, social, and structural factors may influence an individual's health motivations and perceptions but do not directly cause behavioral change (Becker, 1974). The model posits that beliefs are equally important to symptoms, if not more important, in promoting behavioral change (Becker, 1974; Becker & Maiman, 1975).

Research has shown that HBM constructs have particular relevance to women's breast self-examination (e.g., Champion, 1984) and mammography screening behaviors (e.g., Champion, 1999). Data show that women's decisions to engage in breast self-examination and mammography are influenced by perceived benefits (e.g., detecting a lump early will reduce mortality risk) as well as by perceived barriers, including difficulty obtaining an appointment and fear of negative findings. The model has been especially useful in helping identify culturally based beliefs that may promote or hinder screening uptake. For example, Lucía may feel healthy and perceive the absence of symptoms as an indicator of no underlying problems, reducing her likelihood of getting a mammogram. Thus, intervention programs could assist in dispelling the myth that breast cancer requires accompanying symptoms.

Limitations of the HBM include the faulty assumption that cues to action are inherent within an individual's environment, and that these cues are aimed at an end goal of healthy behaviors (Janevic & Connell, 2018). This model also inaccurately assumes that everyone has an equal understanding of what healthy behaviors are, as well as equal access to information and resources needed for these behaviors to occur (Janevic & Connell, 2018).

Social Cognitive Theory (SCT; Bandura, 1971)

SCT is one of the most commonly used theories in health promotion and disease prevention. This theory posits that the interaction between personal factors, current behaviors, and social and physical context shape new behavior (Bandura, 1971, 1985). According to this theory, although individuals have the power to engage in self-determined goal-oriented behaviors through their own actions (e.g., healthy eating, stress management), certain social and cognitive outcomes (e.g., perceived pleasure, positive social reactions, self-satisfaction from engaging in self-determined goal behaviors) are necessary for these goal behaviors to occur and be sustained. This theory also posits that health promoting behaviors contribute to positive mental health outcomes (Bandura, 2004).

Although SCT can be applied to various health promoting behaviors, it is particularly relevant for promoting behaviors in which self-efficacy beliefs play a pivotal role. According to Bandura (1977, 2004), perceived self-efficacy is necessary in initiating and maintaining behavioral change, and efficacy beliefs

strongly predict treatment adherence and relapse among individuals seeking changes. For instance, self-efficacy beliefs and outcome expectancies were found to predict alcohol, marijuana, and other drug use in a sample of young adults (Cohen & Fromme, 2002). In addition, self-efficacy beliefs were found to predict alcohol consumption among community and clinical samples of adults (Hasking & Oei, 2002). In programs designed to facilitate reduction or cessation of substance use, counseling psychologists can (a) identify patients' sources of relevant self-efficacy; (b) foster the clients' understanding of how these source factors have been shaped by their experiences, social influences, and emotional arousal; and (c) use this shared understanding to help plan treatment interventions that strengthen self-efficacy beliefs, thereby facilitating lasting behavior change (Bandura, 1977). In addition to enhancing a person's self-efficacy, counseling psychologists typically possess the values and knowledge to strengthen collective efficacy among families, communities, and organizations. In working with Lucía, counseling psychologists could foster her self-efficacy and confidence that she can overcome environmental barriers (e.g., limited availability of interpreters, financial costs) to consistently engage in health screening behaviors.

SCT is consistent with the values of counseling psychology in its focus on health promotion through personal empowerment, recognition of value systems and social and physical context variables, and integration of science and practice. However, SCT does not include a focus on specific skills needed for personal empowerment and engaging in self-determined goal-oriented behaviors within the context of one's physical and cultural environment (Janevic & Connell, 2018). Counseling psychologists have the multicultural training and the consultation and research strengths needed to identify the aforementioned skills and integrate them into patient care.

Theory of Planned Behavior (TPB; Ajzen, 1991)

Based on the theory of reasoned action (Ajzen & Fishbein, 1980), the TPB aims to explain all behaviors over which individuals can exert self-control (Ajzen, 1991). The latter theory posits that individuals will have intentions to perform a behavior when attitudes and subjective norms are favorable for them to engage in and maintain that behavior. According to Ajzen (1991), individuals will perceive they have behavioral control in relation to a behavior when they perceive that the behavior is controllable and that they have the ability to perform the behavior (i.e., they experience high self-efficacy).

TPB has been applied to a broad range of health-related outcomes such as cancer screening, cardiac rehabilitation, condom use, and exercise. For instance, TPB has been effectively used in increasing attendance at cardiac rehabilitation centers (Mosleh, Bond, Lee, Kiger, & Campbell, 2014). Notably,

across a sample of injecting drug users, commercial sex workers, men who have sex with men, and individuals with multiple sexual partners, condom use was most strongly predicted by attitudes, social norms, and perceived control (Kasprzyk, Montaño, & Fishbein, 1998). Given such findings, it is important that interventions designed to promote a target behavior address (a) the client's perceived control over the target behavior, as well as (b) social factors that are likely to influence attitudes and intentions related to engagement in that behavior (e.g., social norms). A limitation of the TBP is its minimal focus on emotions and individual differences in attending to social norms, both of which can have a significant influence on a person's ability to make behavior changes (Janevic & Connell, 2018). Therefore, in working with Lucía, who knows that a mammogram can detect cancer in the early stages, counseling psychologists could enhance her intent to obtain the screening by attending to social norms. For example, they might invite Lucía to identify a "buddy" who also needs a mammogram to encourage each other and be accountable to obtain the screening exam.

Health Self-Empowerment Theory (HSET; Tucker, Butler, Loyuk, Desmond, & Surrency, 2009; Tucker, Daly, & Herman, 2010)

HSET is a health promotion theory in which health motivation, self-efficacy, self-praise, responsibility and knowledge, and use of problem-focused coping skills to manage stress, depression, and other emotions are key factors in promoting healthy behaviors (e.g., adequate sleep, healthy eating, physical activity, stress management). In turn, these health behaviors prevent the occurrence of diseases and promote positive health outcomes. Specifically, the theory posits that (a) HSET variables interact to positively influence each other; (b) health knowledge, health responsibility, and coping styles and skills have an indirect positive influence on the occurrence of health-smart behaviors (i.e., health-promoting behaviors), whereas health motivation, health self-efficacy, and health self-praise have a direct positive influence on the occurrence of health-smart behaviors; and (c) the occurrence of health-smart behaviors has a direct positive influence on health outcomes and prevention of chronic diseases. HSET acknowledges the intractable social, biological, genetic, economic, ecological, and cultural variables that undermine the occurrence of health-smart behaviors; as such, this theory asserts that these behaviors can occur among individuals when they are empowered with the psychological resources (e.g., self-motivation, self-praise), education, and skills to engage in these behaviors across contexts.

HSET has been used to develop the Health-Smart Behavior Program, commonly called Health-Smart, which is a culturally sensitive, evidence-based, 8-week prevention and intervention program designed to prevent and reduce obesity and related diseases (Tucker, Butler, et al., 2014; Tucker, Williams, & Kang, 2017). Each program participant (a) identifies health-smart goals (e.g., increase water consumption from two to four cups per day), motivators and barriers to attaining these goals, and practical strategies for overcoming the identified barriers; (b) participates in eight weekly group sessions to watch and discuss segments of a Health-Smart DVD that feature culturally diverse counseling psychologists, physical fitness experts, physicians, dietitians, and other health professionals teaching strategies for engaging in health-smart behaviors (e.g., engaging in healthy eating, physical activity, and sleep hygiene; managing stress, depression, and anger); (c) reviews sections of a Health-Smart Resource Guide that provides more detailed health promotion information than the Health-Smart DVD and presents strategies for taking control over and responsibility for health-smart behaviors; and (d) participates in a panel session in which an interdisciplinary group of health professionals answer participants' anonymous physical and mental health-related questions.

Participants in the program are empowered to (a) identify their own goals, related barriers, and motivators; (b) customize what they learn in the group sessions to fit their own lives; and (c) teach each other healthy tips and strategies that prevent or reduce obesity and related diseases (e.g., type 2 diabetes, hypertension). A limitation to HSET is its minimal attention to the need for social support (e.g., external praise and encouragement) in initial efforts by individuals to learn and use health self-empowerment behaviors and skills. In applying this theory with Lucía, counseling psychologists may foster her sense of empowerment by providing culturally relevant psychoeducation that addresses cultural beliefs and knowledge, promoting her skills for managing stress and depression, teaching her to navigate the health care system, and encouraging her to use self-praise and ask for desired external praise and support as she engages in health-smart (health promoting) behaviors.

Relapse Prevention Model (RPM; Marlatt & Gordon, 1985)

Based on SCT, this theory focuses on addressing the challenge of maintaining long-term behavior change (Marlatt & Gordon, 1985). Developed in the 1980s, it was initially used to help address addictive behaviors and promote coping with relapse (Marlatt & Gordon, 1985). Specifically, the RPM posits that relapse is influenced by two categories of factors: immediate determinants and covert antecedents (Hendershot, Witkiewitz, George, & Marlatt,

2011; Marlatt & Gordon, 1985). Immediate determinants refer to high-risk situations such as negative emotional states, interpersonal conflict, and external cues that threaten a person's sense of control over a behavior. Covert antecedents refer to lifestyle factors that influence an individual's exposure to high-risk situations.

Consistent with a strengths-based perspective, the RPM views relapse as a transitional process rather than a failure or end state. The model is used largely with alcohol use and smoking behavior (Hendershot et al., 2011). More recently, it has evolved in its practice to include mindfulness-based relapse prevention (Bowen, Chawla, & Marlatt, 2010). Counseling psychologists could incorporate this approach when working with Lucía. In particular, they may help identify immediate determinants or covert antecedents to relapse (e.g., fear of being told she has cancer) and develop Lucía's ability to cope with the determinants which interfere with her commitment to lasting behavioral change. A limitation of the RPM is its lack of attention to the explicit knowledge, skills, and motivation needed to avoid high-risk situations, particularly in high-risk communities (e.g., low-income communities) where lifestyle and environmental factors that influence individuals' exposure to high-risk situations are often intractable (Janevic & Connell, 2018).

Patient-Centered Culturally Sensitive Health Care Model (PC-CSHC Model; Tucker, Herman et al., 2007)

The PC-CSHC model and corresponding tools for assessing major aspects of patient-centered culturally sensitive health care are examples of the contributions that counseling psychologists are making to improve physical health behaviors. This empirically supported model was developed to explain the associations between the delivery of patient-centered culturally sensitive health care and patient outcomes (e.g., treatment adherence; Tucker, Herman et al., 2007). Specifically, according to the model, patient-centered culturally sensitive health care is "reflective of culturally diverse patients' perceptions regarding the health care characteristics that enable these patients to feel comfortable with, trusting of, and respected during the health care process" (Tucker, Arthur, Roncoroni, Wall, & Sanchez, 2015, p. 64). Specifically, the model posits that (a) patients' perceptions of provider cultural sensitivity are positive predictors of their trust in providers, satisfaction with providers, and perceived interpersonal control in patient–provider interactions, and are negatively associated with stress; (b) patients' satisfaction with providers and perceived interpersonal control in patient–provider interactions are positive predictors of treatment adherence; (c) patients' stress negatively predicts treatment adherence; and (d) treatment adherence positively predicts beneficial

health behaviors and health outcomes (Tucker, Marsiske, Rice, Neilson, & Herman, 2011).

The PC-CSHC model has been particularly useful in identifying ways to help health care staff attract and retain Black/African American patients (Burgess, Ding, Hargreaves, Van Ryn, & Phelan, 2008; Tucker, Moradi, Wall, & Nghiem (2014) and English-preferred and Spanish-preferred Latino patients (Nielsen, Wall, & Tucker, 2016). The Tucker-Culturally Sensitive Health Care Provider Inventory (Tucker, Nghiem, Marsiske, & Robinson, 2013) was developed and empirically validated in an effort to assess patient-perceived and patient-defined cultural sensitivity of providers. This inventory is currently used in health care settings by counseling psychologists, clinical psychologists, health care providers, and other health care professionals across the United States.

The PC-CSHC model is unique in that cultural sensitivity is considered a major factor in health care promotion. In addition, cultural sensitivity is defined and evaluated by patients, rather than by professionals. Given that intractable social determinants of health are major causes of health disparities, it is important to use patient empowerment models such as the PC-CSHC model to guide efforts aimed at enabling minority patients and other patients with limited actual and/or perceived power to take charge of their health. Such patient empowerment is consistent with a social justice perspective, a core value in counseling psychology. As illustrated in our case example, counseling psychologists can incorporate the PC-CSHC model into Lucía's treatment to foster empowerment. In turn, counseling psychologists could work with interdisciplinary health care professionals to identify and promote aspects of cultural sensitivity, as identified by Latina women such as Lucía, that may effect change on a broader level (e.g., hiring and training professional interpreters that would facilitate communication with immigrant Latina women in a confidential and sensitive manner). A limitation of the PC-CSHC model is that it does not recognize the importance of emotions other than stress (e.g., depression). Additionally, more research is needed to test this model with various marginalized patients.

Wheel of Wellness Model (WOW Model; Myers & Sweeny, 2008)

The WOW model is a health promotion and prevention-focused theory that is consistent with the values of counseling psychology; specifically, it is strength-based and challenges the traditional, illness-based approach to treating mental and physical health problems. Furthermore, this model is client-centered, multidisciplinary focused, and holistic. It is holistic in that it conceptualizes physical health, mental health, and spirituality as positively related concepts. The model

asserts that physical health, quality of life, and longevity are related to five life tasks: spirituality, self-direction with regard to engaging in health promoting behaviors, work and leisure, friendship, and love (Myers & Sweeny, 2008).

A major strength of the WOW model is that it includes spirituality as a life task. This is important given that spirituality and/or religiosity have been associated with low stress levels, high levels of mental health functioning (Koenig, Larson, & Larson, 2001; Koenig, 2012), and positive physical health outcomes for various cultural groups (Koenig, 2012; Koenig, King, & Carson, 2012; Schwingel & Gálvez, 2016). For instance, Lucía may identify her spirituality as an essential component of her identity. Counseling psychologists could incorporate aspects of her spirituality in promoting her overall psychological and physical health. Given that the WOW model is multidisciplinary, it has the potential to inform prevention and health promotion interventions in health care settings where individuals from multiple disciplines work to promote the overall health of culturally diverse patients.

There are some notable limitations of the WOW model. First, this model does not adequately address the systems that act upon a client's self-directed choices and behaviors. Second, it employs a directive approach to treatment that may not work well for all clients and does not include the patient's perspective on the desired treatment. Despite research highlighting the importance of holistic wellness across contexts and settings, additional research is needed to more comprehensively reflect the complexity of the WOW model and its cross-cultural applicability (Mayer, 2017).

Community Wellness Model (CWM; Prilleltensky, 2005)

According to the CWM, well-being consists of sites, signs, sources, and strategies. *Sites* are the location of the well-being (i.e., personal, relational, or collective). *Signs* are manifestations of well-being expressed at the three different sites; that is, signs are ways of knowing that well-being is present at the three different sites. *Sources* are groups of determinants corresponding to each site; for example, self-determination exists at the personal site whereas access to health care and high-quality health education exist at the collective site (Prilleltensky, 2005). Successful strategies to promote wellness must respond to all of the sites, signs, and respective sources of well-being at any given time (Prilleltensky, 2005). Broadly defined, *wellness* refers to the positive state of affairs that emerges from the simultaneous and balanced satisfaction of personal, relational, and collective needs at the individual and community levels (Totikidis & Prilleltenksy, 2006). The state of wellness is characterized by a person feeling that they matter—feeling valued, appreciated, respected, and recognized; furthermore, the person feels that they can make contributions that are valued (Prilleltensky, 2019).

The CWM is action-oriented, strength-based, preventive, proactive, empowering, and focused on a range of well-being domains (i.e., personal, relational, and community) as well as an array of signs and sources (Prilleltensky & Prilleltensky, 2003b; Prilleltensky, 2005). This bears contrast with traditional, individual-focused health empowerment strategies that only focus on a limited set of signs and sources.

A strength of the CWM is its recognition that wellness is both psychological and political, as is liberation (Prilleltensky, 2008). It posits that (a) power is omnipresent at all three wellness sites (i.e., personal, relational, and community), privileging the powerful and discriminating against the weak, and (b) successful health promotion efforts mandate addressing material deprivation, equality in distribution of resources, and social cohesion (Prilleltensky & Prilleltensky, 2003b). The model also posits that critical praxis (e.g., the work of health psychologists as social change agents) and professional responsibilities as traditionally defined must be melded to reduce health disparities (Prilleltensky & Prilleltensky, 2003a). In working with Latina clients such as Lucía, counseling psychologists can incorporate the CWM to attend to these systemic and community factors (e.g., foster community partnerships that can provide free mammography screenings at a location where medically underserved Latina women live).

The CWM has been cited extensively, as it is a powerful framework that supports the notion that an individual's health outcomes are not limited to the absence of disease, but comprise a total state of wellness that arises within the context of a larger community (e.g., Arora et al., 2016; D'Abundo & Carden, 2008). The wellness of the larger community thus influences individual, relational, and organizational well-being (Prilleltensky, 2012). To our knowledge, however, this model has not been applied to the academic training and practice of behavioral health care by counseling psychologists. There is much promise in the application of this model, as it is consistent with counseling psychology's values related to the promotion of social justice, healthy development, multicultural competence, and educational perspectives. Thus, research is needed to examine the most effective ways to incorporate CWM perspectives in the practice of behavioral health care by counseling psychologists.

Implications for Theory, Research, Training, Practice, and Advocacy

Implications for Theory Development

Counseling psychologists, particularly those who are scientist-practitioners, have the needed training to assume leadership in developing culturally sensitive theories that highlight the bidirectional relationship between mental

health and physical health. Development of such theories requires (a) obtaining input from members of culturally diverse communities regarding their views on the relationship between mental health and physical health, (b) reviewing the limited relevant research on this relationship, and (c) consulting with health care professionals regarding this relationship. Notably, counseling psychologists recognize that one theory may not fit all individuals, and that theories must account for the multilevel social determinants of mental and physical health (e.g., economic, cultural, educational, environmental, and gender-, sexual orientation–, ethnicity-, race-, and racism-related factors; Paskett et al., 2016). A focus on developing culturally sensitive theories that are applicable for use with groups most negatively impacted by health disparities, such as racial and gender minorities and the poor, is needed.

It is also important for counseling psychologists to challenge foundational mental health- and physical health-focused theories that have been created by privileged White men using majority samples. Examples of the most popular among such theories are cognitive-behavioral theory, cognitive theory, SCT, the HBM, and the TPB. All of these theories have a major focus on personal factors that influence mental and/or physical health, with little or no attention to the larger sociopolitical context of the determinants of health. Additionally, the studies that provide support for these theories typically include limited or inadequate samples of minorities, with instances in which the race, ethnicity, or gender composition of participants in the studies were not reported (e.g., Ashworth et al., 2015).

It is critical for counseling psychologists to acknowledge the significant limitations of these theories, if we are to move beyond an examination of only individual-level factors. Theories are needed that can help guide the creation of multilevel interventions, consistent with the cultural needs of the populations we serve. To adequately capture cultural issues, it is also important for theories to be developed in consultation with culturally diverse researchers and community members and in a manner that shows respect for and promotes comfort and trust among these individuals. Notably, it is important for counseling psychologists to develop culturally sensitive theories that help explain the bidirectional relationship between mental and physical health.

Implications for Future Research

There is much justification for counseling psychology as a field to support and lead health promotion and disease prevention research efforts. Research is needed that (a) further documents the relationship between mental health and physical health, (b) is conducted by multidisciplinary, racially and/or

ethnically diverse research teams, (c) is culturally sensitive, (d) aligns with reducing health disparities, and (e) advances health and health care justice. Notably, cultural sensitivity extends beyond cultural competence (i.e., having the knowledge, skills, awareness, and experiences needed to provide counseling and other interventions to diverse clients) to include demonstrating this competence in ways that enable clients to feel comfortable with, trusting of, and respected by researchers, counselors, and other care providers. Furthermore, cultural sensitivity refers to being aware of and responsive to the existence of biases held by clients, patients, and providers, and recognizing that client–provider relationships ideally recognize both the clients and providers in these relationships as experts and partners (Tucker, 2019).

In addition, it is important for counseling psychologists to evaluate the effectiveness of theories that link mental and psychological variables to physical health outcomes. It is particularly important to test those theories and models that are culturally sensitive (e.g., the HSET, PC-CSHC model) using gender and racial and/or ethnic minority and other marginalized patients. Ideally, all theories that are relevant to behavioral health and behavioral health care should be informed by the lived experiences of patients with low health literacy and/or limited language competence, and/or who experience discrimination on the basis of race, ethnicity, gender identity, and/or sexual orientation.

Implications for Practice

A major gap in efforts to promote physical health through behavioral health and behavioral health care is the absence of identified standards and competencies to guide these efforts (see Boland et al., 2019). Counseling psychologists are uniquely situated to contribute to such standards; however, the development of such standards require the collaborative efforts of counseling psychologists, health care professionals, and community members as well as representatives from the American Psychological Association Commission on Accreditation.

It is clear that counseling psychology professionals and trainees can, and ideally should, engage in behavioral health and behavioral health care practice activities that foster prevention of disease, promotion of mental and physical health, and reduction in health disparities in minority, low income, and medically underserved communities—activities that are consistent with their core values regarding multiculturalism and social justice (Nilsson et al., 2019; Perrin & Elliott, 2019). Specifically, these practice activities need to include (a) holistic counseling (which addresses mental health, physical health, and spiritual health); (b) advocacy for health and health care justice as

part of social justice; (c) consultation and intervention in health care settings, with the aim of promoting culturally sensitive and patient-centered care; and (d) implementation of health promotion and prevention programs in churches, schools, and other community settings.

In this effort, counseling psychologists should expand collaborations with colleagues in allied fields (e.g., kinesiology, nutrition, physical education) and settings (e.g., university hospitals, community wellness centers, gyms and athletic clubs, yoga and mindfulness programs) as well as community members and their church leaders. Specific roles counseling psychologists can assume as members of behavioral health and behavioral health care teams to promote health and prevent mental, physical, and emotional disorders include assessing and facilitating patients' (a) readiness for behavioral change, (b) barriers to health promoting behaviors, (c) motivation to engage in health promoting behaviors, and (d) self-perceived strategies for engaging in and maintaining healthy lifestyles.

Implications for Training and Education

To strengthen their ability to contribute to behavioral health and behavioral health care and related research and theory development, counseling psychologists need to develop interprofessional skills as well as skills in working with communities. In addition, counseling psychologists need to have an active understanding of the bidirectional relationship between mental and physical health. As researchers, counseling psychologists and their students may benefit from greater training and supervision in the use of specific research methods that traditionally have not been emphasized in their training (e.g., community-based participatory research, qualitative research, mixed methods research, and patient-centered research). Additionally, these individuals may benefit from learning to develop and implement culturally sensitive intervention model programs (e.g., Health-Smart) that include a focus on health outcomes. It is also important for counseling psychology trainees to take courses on behavioral health, behavioral health care, health policies, and the social determinants of health—courses often taught in clinical and health psychology and/or public health programs.

Counseling psychology students will likely benefit from strong encouragement to choose one or more practica in health care sites in order to learn about health care systems and identify potential research collaborators within such sites. Counseling psychologists could meet with health care providers to learn about the mental health and physical health care challenges that patients experience, and subsequently initiate intervention research collaborations with these providers toward the goal of identifying effective strategies to address these challenges.

Implications for Advocacy

Notably, there is no social justice without health and health care justice. Thus, it is important that counseling psychologists also assume leadership in promoting mental and physical health. As proposed by Tucker, Ferdinand, et al. (2007) and Prilleltensky and Prilleltensky (2003a), counseling psychologists can adopt a critical stance that (a) balances the prevalent emphasis on personalized care with integrated care; (b) creates equitable partnerships among medical professionals, patients, and community members; (c) ensures that problems are conceptualized in the context of these partnerships; (d) centers patients and community members as well as mental and health care providers as experts; and (e) is anchored in proactive approaches to health promotion and prevention.

Counseling psychologists are well-positioned to organize national conferences that feature research and evidence-informed interventions that address the relationship between mental health and physical health. Such conferences could also promote collaborations among psychologists, medical professionals, complementary medicine professionals, patients, and community member stakeholders aimed at fostering culturally sensitive holistic care. Counseling psychologists can also become leaders in promoting mental and physical health by training community members to be health empowerment coaches and partners in their communities. A good example of such training provision is the recent development of First Aid Mental Health (Kantor & Beckett, 2011)—a collaborative mental health education program that focuses on empowering community members to recognize and address acute events such as panic attacks and strokes.

Counseling psychologists can lead the development of education programs, particularly ones that focus on psychological symptoms associated with physical health problems toward the goal of early intervention. These professionals can also become leaders in advocating for a life-course approach to understanding the association between mental and physical health (WHO, 2014). There is a particular need for life course studies that assess and evaluate the influence of interventions and/or policies to remove barriers to mental health and physical health in minority and other underserved communities (e.g., telepractice; Cooper, Campbell, & Smucker Barnwell, in press; Herman, Reinke, & Thompson, 2017; Tucker, Butler, et al., 2014). Findings from these studies, in turn, may form the basis for future physical and/or mental health promotion policy-making.

Advocacy, community organizing, and policy work courses and field experiences are still a small part of most counseling psychology training programs (Hargons et al., 2017; Vera, 2018); additionally, the body of literature that systematically evaluates the impact and outcomes of these courses and

experiences is also still small (e.g., Goodman, Wilson, Helms, Greenstein, & Medzhitova, 2018). Furthermore, the benefits of civil disobedience, sabotage, protest, and other direct-action methods to reduce health disparities are not thoroughly explored in counseling psychology doctoral training programs and other higher education venues (Olle, 2018). Counseling psychologists can lead this exploration, and contribute significantly to a timely social justice issue—the amelioration of health disparities.

Conclusion and Recommendations

Given counseling psychologists' traditional focus on prevention, education, multicultural issues, assessment, and social justice, it is a natural transition for them to take advantage of the many opportunities to engage in prevention in behavioral health and treatment and prevention in behavioral health care. We conclude this article with 15 recommendations for counseling psychologists to engage in behavioral health and behavioral health care.

1. Consider challenging theories based on the worldviews of predominantly White theorists and researchers living in predominantly White cultural environments. Similarly, focus on reducing health disparities by designing interventions that challenge traditional assumptions of these theories that may perpetuate privilege and oppression (DeBlaere et al., 2019; Grzanka et al., 2019).
2. Account for patients' perspectives when expanding on existing theories and developing new frameworks (e.g., Friedlander et al., 2019; Tucker, Herman, et al., 2007).
3. Given the need to incorporate perceptions of community members in behavioral health research, consider using both quantitative and qualitative methodologies that attend to multicultural issues and aspects of diversity (Suzuki, O'Shaughnessy, Roysircar, Ponterotto, & Carter, 2019).
4. Engage in consultation in health care settings to infuse strength-based, preventive, educational, and multicultural values as part of behavioral health care (e.g., Berkel et al., 2019; Boland et al., 2019).
5. Advocate for gender-affirming health care practices for trans individuals (Goldberg et al., 2019).
6. Given disproportionate effects of trauma on marginalized populations, engage in tailored trauma-informed practice within health care settings and contexts (Inman et al., 2019; McAndrew et al., 2019).
7. Engage in community behavioral health efforts that empower patients to take charge of their physical and mental health (DeBlaere et al., 2019; Tucker, Williams, & Kang, 2017)

8. Become a catalyst for change by facilitating dialogue among members of interdisciplinary teams on issues of race, gender, sexual orientation, and intersecting identities (e.g., Grzanka et al., 2019).
9. Consider attaining competence in telepractice to reach those patients who have the greatest barriers to care (Cooper, Campbell, & Smucker Barnwell, in press).
10. Expand opportunities for practicum experiences and postdoctoral internships within health care settings (e.g., hospitals, community clinics, VAs, holistic medicine centers; Boland et al., 2019)—opportunities that will ready counseling psychology trainees to be part of interdisciplinary behavioral health care teams.
11. Provide training in health care settings to better support marginalized patients, including trans patients (Matsuno & Israel, 2018). Similarly, provide supervision within settings where counseling psychologists are typically underrepresented (McAndrew et al., 2019).
12. Gain expertise in techniques that apply to mental and physical health promotion, such as motivational interviewing (e.g., Boland et al., 2019)
13. Pursue continuing education opportunities focused on prevention and health promotion within the field of behavioral health.
14. Step out of the traditional therapist role in order to advocate for clients (e.g., Goodman et al., 2018).
15. Serve on hospital and clinic decision-making boards to provide alternative perspectives based on counseling psychology values (Boland et al., 2019; McAndrew et al., 2019).

In sum, we are calling the attention of counseling psychologists and their trainees to the unique strengths that they can bring and are increasingly bringing to the promotion of behavioral health and behavioral health care—two growing areas with much potential for prevention, health promotion, and improving health quality and associated health care. We are challenging counseling psychologists to move beyond the comforts of their research labs and counseling offices to (a) gain the experiences needed to be culturally sensitive theorists, researchers, educators, consultants, and advocates in our field; and (b) prepare themselves to work as influential members of multidisciplinary behavioral health care teams—the kinds of teams needed to address the multilevel social determinants of health (e.g., poverty, racism, sexism, and discrimination based on religion and gender) that often impede and deter health care utilization and holistic health promotion. Finally, we are challenging counseling psychologists to be drum majors and interventionists for health and health care justice—roles that are consistent with the values of counseling psychology and that are key to reducing health disparities that plague the United States and negatively impact all who live within this country.

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We dedicate this article to the memory of Tasia Smith, PhD, who passed away unexpectedly on December 5, 2018. She was the daughter of Reverend Jessie McLendon and Mr. Nathaniel Smith. Dr. Smith had been mentored by Carolyn M. Tucker, PhD, and was the third author of this paper. She graduated from the doctoral program in counseling psychology at the University of Florida in 2016 and immediately assumed the position of Evergreen Assistant Professor in the Department of Counseling Psychology and Human Services at the University of Oregon. Her research focused on the prevention and reduction of obesity and obesity-related health disparities among underserved populations. A relentless advocate for vulnerable communities, Dr. Smith helped develop health promotion tools that are currently being used by professionals across the nation. We hope readers will be inspired by reading this paper as much as those of us who knew her were touched and inspired by her.

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