HELPING UCI TO BE FIT FOR EXCELLENCE

By Thomas A. Parham, Ph.D.
Assistant Vice Chancellor, Counseling and Health Services
Director, Counseling Center
Welcome Letter & Explanations - 1

Yolanda Moses - 2
Britt Rios-Ellis - 8

Acknowledgements - 10
A visit from the Surgeon General — inside back cover
Building Blocks to Wellness — back cover

Office of the Assistant Vice Chancellor
Counseling and Health Services
202 Student Services I
Irvine, California 92610-2200
During the past five years, I have had the opportunity to lead a cluster of units on UCI's campus known as Counseling and Health Services. These units are charged with coordinating the delivery of a broad range of mental and physical health services which are designed to meet the needs of students and other members of the campus community.

Beyond engaging in the delivery of direct service, we are challenged to elevate our domains of intervention from tertiary levels to primary preventions. Afterall, it is primary prevention that offers the greatest hope addressing a myriad of health related concerns. In that spirit, we offer this booklet to help disseminate information about health promotion efforts.

Within these pages you will find different perspectives on health and wellness. The U.S. Surgeon General Dr. David Satcher shares his prescription for a healthy nation. Dr. Yolanda Moses, President of the American Association of Higher Education, discusses her ideas about creating an academic community of wellness, and Dr. Britt Rios-Ellis, Associate Professor of Health Services at California State University, Long Beach, highlights the need to move toward a greater community of optimal wellness.

In providing you with this information, it is also my hope to challenge your sensibilities about the nature of health, and the need to expand our definitions beyond the physical realm. Afterall, restricting our focus to physical health alone and ignoring emotional, social and even spiritual dimensions of health is a posture that we must rethink. Indeed, true wellness is a holistic construct that demands a more comprehensive focus.

I am proud to share with you this information and hope that these materials will serve as your personal invitation to a more healthy lifestyle.

Sincerely

Thomas A. Parham, Ph.D.
Assistant Vice Chancellor,
Counseling and Health Services
Director, Counseling Center
Wellness and Excellence: Educating the Whole Student

by Dr. Yolanda Moses, President of the American Association of Higher Education (AAHE). She discusses the requirements for creating an academic community of wellness. You will find her discussion very interesting.

"Thank you for the invitation to come speak with you about the subjects of wellness, the university environment, and student success. It is clear to me that there is the life of the mind as well as the spiritual side and the physical side of a student's life. The role of a university is to educate that whole person. We are so fragmented in our approach that we sometimes lose sight of that fact.

This paper will explore several themes in an attempt to present a vision of what the university would look like truly focused on educating the whole student. The first section will explore who our students are in the 21st Century: their demographics, their needs, their desires and expectations. Part II focuses on issues that effect the success of students, their challenges and their opportunities. And Part III represents a description of the engaged campus, that 21st Century institution that creates a space for students to be all that they can be.

Part 1: Educating the Whole Student

Overall, there are more students attending college and universities than ever before. They are diverse in age, socioeconomic status, gender, race and ethnicity, sexual orientation and learning and physical ability. Their diversity today may be greater than at any other time in human history. The traditional 18-year-old college-aged student is giving way to the older, adult student who may be attending part-time as well as full time.

Students vary in many other ways. The socioeconomic status of today's students ranges from those families who are able to finance their education fully, to adults whose incomes must also cover family expenses, to low income students who require financial assistance.

Women currently make up the majority of most undergraduate student bodies; women's changing educational and political interests have expanded in some traditionally male-dominated fields; their increased presence and different needs have altered campus services and raised the issue of bias toward particular groups of students (El-Khawas 1996). Members of historically underrepresented racial and ethnic groups-African American, Hispanic, Asian American, Native American, and foreign nationals, now constitute approximately one fourth of today's undergraduates (Carter and Wilson 1995). Such heterogeneity in the student body requires the expansion of perspectives taught in higher education. It also requires education communities open to differences, as well as new and varied pedagogies and assumptions about levels of preparation, learning styles, and available time for study. Awareness of and openness to differences are also crucial to the growing population of gay, lesbian, and bisexual students whose marginalization affects their educational experience. Similarly, students with disabilities-whether physical, learning, or health related-are attending college in increasing numbers and require accommodations to maximize their educational opportunities (Magolda and Terenzini 2001).

Students increasingly are coming from single-parent homes, have experienced mental or physical abuse, have experienced substance abuse, and seek counseling for personal and family mental health issues during the college years (Upright 1994). Levine and Cureton report that students are coming to college overwhelmed and more damaged than those of previous years (1998, 1999). Their statement is based on increases in use of psychological counseling services, eating disorders, classroom disruption, alcohol abuse, gambling, and
suicide attempts. The complexity of this student body produces multiple educational goals, learning approaches, and situational factors that can present instructors and administrators alike with a major set of new challenges.

Part II: Issues that Effect College Students

In this section I want to focus on four major issues that are of profound concern to college and university students: managing stress, countering violence, testing the value of diversity, and binge drinking.

Stress-We all know that college life can be very stressful. Sometimes we adults tend to idealize our college experience. But to students currently attending universities, the process is often stressful and frustrating. The competition for grades, the need to perform, relationships, a fear of AIDS, career choices, and many other aspects of the college environment cause stress.

Stress can be a normal condition, and is only harmful when it is excessive. Much of the stress we all experience is helpful and stimulating. Most students and people tend to see stress as caused by external factors, often called stressors. Sometimes it is a particular test, or a professor or situation that will "stress them out." Stressors tend to be caused by the environment (what is happening externally), by the mind (what you think), and the body (a student's emotional reaction and physical components).

Often, it is not the situation itself that causes the stress, but the negative thinking that goes on around it. For example, an honor student that is accustomed to getting A's receives a C-this can cause stress. But, a student should see this in perspective. One grade of a C does not really mean that the student is a failure. This kind of faulty interpretation can impact a student at a personal level as well. Breaking up with a boyfriend or girlfriend can be seen as a terrible failure and students may imagine they will never have another relationship. This can cause great stress even though the interpretation of the event is irrational.

Clearly, the way students interpret or think about events affect their perspectives and experiences of stress. Stress reactions to various situations are also affected by students' overall health. Someone who is always overwhelmed, eats poorly, and doesn't get enough sleep usually has limited ability to cope with stress. Students should pay attention to their own well-being. The right balance of sleep, food, exercise, work, school and recreation is crucial.

Violence-Domestic violence is the leading cause of injury to women ages 15-44 in the United States. Statistics also reveal that among women who reported being assaulted since the age of 18, 76% were victimized by a current or former boyfriend, husband or date. Many students arrive at college unaware of the dangers that relationships can present. They sometimes learn with scars that never completely heal. Contrary to many students' beliefs, college campuses are not exempt from violence. In a nationwide survey by Security on Campus, Inc., 59% of college students reported that either they or a close friend or relative had been the victim of domestic violence. One out of five college students reported at least one incidence of abuse in his or her relationships.

It will be particularly important for colleges and universities to provide the emotional support for students who have been abused, and as safe an environment as possible for students to be free from fear of abuse.
Part II: Issues that Effect College Students (continued)

Diversity
We often talk about diversity in terms of race, ethnicity, or religious beliefs, but in a college atmosphere dedicated to the sharing of knowledge, diversity of ideas is perhaps the most manifest type of diversity, one that easily encompasses all of the others.

Because we learn from experience, and because each of us has experienced different things, we all view the world in very different ways, despite the physical traits that we may or may not have in common. Because we cannot always share the experiences of those we meet, we must instead share the insights that someone else has gained. To do this, we must listen to their ideas with an understanding that there is not one correct perspective, only the one that fits us best.

Campus living provides contact with a variety of people that is rarely found in such a concentration anywhere else. In a world where we deal with people of ethnic groups worldwide through many different media, there should be no place for prejudice of any kind. The college experience is more than four years of classes. The time students spend sharing ideas is perhaps the most valuable form of education, because outside of college people don't spend time writing papers for teachers or taking tests over book material.

Patricia Gurin, Professor at the University of Michigan, indicates that college students who experience the most racial and ethnic diversity in classrooms and during interactions on campus become better learners and more effective citizens, according to an analysis conducted at the University of Michigan. She further indicated that all students, non-minority and minority alike, learn better when the learning takes place in a setting where they were confronted with others who are different from themselves.

It will be the role of colleges and universities to create the environment in which the diversity can thrive. The real test will be whether graduates can take on a global attitude and realize that all ideas are equally valuable.

Binge Drinking - Excessive drinking is now recognized as the leading threat to the health and well-being of college students. In addition, research suggests that alcohol consumption is a strong contributing factor to the high incidence of high-risk sexual behavior among many college students as well. No well-developed measure currently exists that measures prospective daily alcohol consumption, daily sexual activity, and the combination and consequences of the two. An alcohol and sexuality log was developed for this purpose and pilot tested with 243 undergraduate students attending a large northeastern university to test its effectiveness. Results indicated that 81% of the students drank alcohol, and 55% of the students engaged in sexual behavior during the seven-day monitoring period. Thirty-eight percent of the students reported either they or their partner had drunk alcohol prior to engaging in some form of sexual behavior.

In addition, students were asked to report on a variety of other factors associated with drinking and sexual behavior (number of drinks, pressure to have sex, etc.). The results from pilot studies like these could be used to guide the development of educational programs on college campuses to decrease risks from mixing alcohol with sex.

Part III: The Engaged Campus

It is increasingly clear that while colleges and universities are doing a good job to promote engagement of their students, faculty and administrators with each other and with the communities that they serve, there is still no comprehensive model that integrates all of these best practices of engagement into one institutional whole. That is what is needed. Institutions like yours, that incorporate research, teaching and service paradigm would be ideal. The phrase "engaged campus" covers a number of overlapping issues and activities involving individuals and institutions of higher education within their communities. Altogether, it rejects the ivory tower image of campus life, and instead promotes curricular changes, pushing for changing the research culture that dominated late Twentieth Century higher education. Various national meetings and manifestos of the past few years have
Part III: The Engaged Campus (continued)

identified a need to clarify the language for a national agenda of democratic engagement, while recognizing that such terms as civic, democratic, and community are themselves contested. The specific categories vary, but components of the engaged campus movement generally include the following concerns:

1. Student learning based on service to community. This movement is built primarily on an interest in effective learning. It connects theory to practice by extending the classroom into the community (service-learning), encouraging problem-based and interdisciplinary learning, and fostering collaborative and democratic pedagogies. At its best, service-learning is not the application of classroom learning; rather, it is the solving of unstructured, complex problems in partnership with a community.

2. The decline of student engagement in civic life of the community or nation measured by political activity, especially voting and participation in traditional social organizations. Many commentators see student disengagement as a serious threat to a vibrant democracy and look to higher education to reverse the trend. They are particularly troubled by the gap between the decline in interest in politics and the rise in volunteerism. Others counter that the forms of engagement have simply changed for the current student generation, or should be addressed as part of the call for civic renewal by all members of society.

3. A renewed interest in faculty’s public role through action research, professional community service, and community-based teaching and research. This interest is part of the larger movement to redefine faculty work as discovery, learning, and engagement, and to adopt the criteria offered in Scholarship Reconsidered. Interest in civic engagement has spawned a number of publications, meetings, and a national review board for the scholarship of engagement. One challenge has been to define this work as an integrated part of the faculty role rather than one more requirement for faculty.

4. Diversity initiatives that create inclusive, multicultural learning environments to further students’ intellectual and moral development and support democratic pluralism. These initiatives frequently challenge the traditional structures of classroom authority and notions of democratic rights and responsibilities built upon dominant cultural norms. They assert that democracy needs to be built on difference rather than sameness of identity and culture. These initiatives often bring together academic and student affairs and integrate theory and practice.

5. Higher education and community partnerships for community-building. Built upon mutual interest, partnerships may be focused on economic and physical infrastructure, improved schools and health care, and efficient use of limited resources. These partnerships are characterized by the shared authority rather than expert-client or researcher-subject relationships. HUD’s Community Outreach Partnership and the Great Cities Initiatives (formerly the urban 13) are instances of such partnerships.

These concerns have in common a commitment to a broadly inclusive and democratic engagement of campus with community. They have the potential for encouraging life-long learning and shaping a more just society. They also offer solutions to the increasing fragmentation and isolation of work in the academy. However, there needs to be more effective linkages among this cluster of interests so that they reinforce rather than duplicate each other and allow those who are working for democratic engagement to compound rather than dilute resources. Campuses have the capacity to do this work. It takes visionary leadership from the top down in the institution. It starts with the president or chancellor of the university, but it does not end there. Leadership comes
Part III: The Engaged Campus (continued)

from all areas of the campus, whether it be in student affairs, among the faculty or in the student body. The people must be brought together who have a vision of what the campus would look like if it were truly engaged. How would academic affairs work with student affairs, how would the campus leadership discuss and implement rewards for people who participate in research and teaching initiatives that enhance their institutions knowledge both inside and outside of the university or college? These are just a few of the questions that should be asked as the leadership thinks about how to create that environment to support the holistic success of their students.

AAHE, the organization of which I am president, has played an important role in defining the issues of an engaged campus over the past few years through its conferences and publications. In 1995, it sponsored a Colloquium on National and Community Service with the national organization on service learning called Campus Compact. One result was AAHE’s 1 8-volume series of publications on service-learning in the disciplines. Also in 1995, the annual National Conference for Higher Education theme was "The Engaged Campus, Organizing to Serve Society's Needs." The conference was followed by an issue of Change devoted to "Higher Education and Rebuilding Civic Life" (January/February 1997). AAHE’s Forum on Faculty Roles and Rewards has published monographs on Making the Case for Professional Service (1995) and Making Outreach Visible (1999). This past summer, the forum brought together faculty and administrators working in the various fields of the engaged campus to discuss AAHE’s next steps in promoting democratic engagement in higher education.

AAHE and other higher education and disciplinary associations are encouraging campuses to take the next step and move beyond service learning and involve the whole campus in thinking through the issue of what engagement means in the context of your campus. This step would create more collaboration among students, faculty, and community members, extending beyond individual course assignments, and connecting more explicitly service-learning to civic responsibility. Faculty would be involved in broadening the definition of scholarship by focusing on what it means to be scholarly about work done in the community, and how that scholarship can be made publicly available and rigorously evaluated. Through campus-based teaching initiatives, colleges and universities can commit to developing a definition of the scholarship of teaching and enacting it on their campuses. Part of this teaching focus could be also centered on democratic pedagogies and community-based teaching and learning. Finally, the engaged campus model would promote the assessment of student learning to track how these changes impact the institution within and without. It would provide very important information for external publics and stakeholders who may want to know just how effective the changes are.

CONCLUSION

The themes that I have raised in my talk are visionary. We have not achieved those goals of the engaged campus in very many places. But, I think if we are going to truly focus on what the needs of students are, then we have to consider how to make this vision a reality. It will have to be done in a spirit of cooperation, thinking across borders and boundaries, as well as "outside of the box." What better group to take on this task than the leaders that are assembled here today. Transformational change starts with taking the first steps. You have already done that. You are on your way!"
Moving Toward Optimal Community Wellness

by Britt Rios-Ellis, Ph.D., Associate Professor of Health Services at California State University, Long Beach.

Wellness in the context of the United States and other Western countries is often defined on an individual basis. Although this context provides a wealth of opportunities for individual health promotion, it often renders the community without a basis by which to work toward mutual health status. However, community health and individual health need not be juxtaposed as surely the individual striving for a healthy status can achieve this much more effectively within a healthy community.

According to the World Health Organization (1948) health is defined as a state of complete physical, mental, and social well being, not the mere absence of disease or infirmity. Although this definition could be construed to pertain to individual health status, the mention of social well being definitely indicates the positive health gains to be had through interaction with other healthy human beings. When the definition of wellness is examined, the parameters of quality of life begin to become apparent. Wellness can be defined as a quality of life that includes physical, mental-emotional, family-social, and spiritual health. Due to the fact that health is not a stagnant variable and is very multidimensional, this implies a delicate system of life management which requires that the individual be supported by many factors throughout his/her quest for health maintenance.

This process, therefore, obligates a logical structure of contingencies which should enable the individual, within the context of a larger society, to maintain his/her efforts toward a healthy lifestyle. Due to the reciprocity of the individual and the larger society, community health efforts must be made to directly affect the microcosmic level of an individual's world. Community health promotion, therefore, is a requirement of individual health. This can be defined as "any combination of education, social, and environmental actions conducive to the health of a population of a geographically defined area," (Green & Ottoson, 1990). These efforts must also impact each factor of wellness in a constant and positive way to continuously support the healthy development of the individual and the community at large. According to Heinrich Blum (1974), there are four components of wellness which include: environmental factors (both mental and physical, as well as sociocultural factors such as economic status, education, and employment opportunities); lifestyle (which encompasses one's knowledge, attitudes and behaviors regarding nutrition, exercise, stress or life management, and interactive abilities); heredity (one's genetic predisposition); and, medical care services (which embodies preventive and integrative medicine, cure, health care and rehabilitation). These four factors are directly affected by both physical and interpersonal forces such as natural resources, ecologic balance, population size and distribution, cultural systems, and human satisfaction and fulfillment.

The Western world's shift to what has been known as "The Health Promotion Phase" (from 1974 till present) provided the opportunity for the individual to begin to develop and understand the personal influence which can be directed toward attainment and management of a healthy lifestyle. Although this has brought rise to the self help era and has motivated many people to acquire knowledge about ways in which exercise, nutrition and other mechanisms of behavioral modification can improve health status, it has transferred the focus away from societal structure to the more individual as the agent of change. The Health Promotion Phase has shifted the primary focus of disease causation from germs and bacteria to unhealthy personal behavior, which often results in what has become known as "blaming the victim" for his/her poor health status. Even Healthy People 2000, the guiding document for goals and objectives for the health status of the United States, focuses largely on altering individual behavior.

Perhaps the most crucial weakness of this philosophical premise, is that it demands changes in individual behavior without providing the structural organization necessary to insure that appropriate community health and outreach services are available to all persons in society.
Moving Toward Optimal Community Wellness (continued)

Let us consider the renowned Maslow's Hierarchy of Needs. According to Maslow, one cannot reach and maintain self actualization unless she has first acquired physiological needs, safety needs, love needs, and esteem needs. Maslow's model, similar to Hawk's Model of Spiritual Health, requires that physical, intellectual, social, spiritual, and emotional needs are met before one can achieve spiritual health. The major focus of effort to achieve healthy status in the Health Promotion Phase has been through health promotion and education, the premise being that if individuals acquire the knowledge necessary to make healthier decisions, they will make the healthiest decisions possible. However, even the most avid health educator must admit that knowledge is not enough to acquire and maintain a healthy lifestyle. Certain prerequisites, such as those stated in Maslow's Hierarchy of Needs and Hawk's Model of Spiritual Health, must be in place. Members of many underserved populations must often consider the need for immediate survival over long term health outcomes. Living lives comprised of few pleasures, individuals often engage in at-risk behaviors which will provide at least short term enjoyment. In the case of theories such as those of Maslow and Hawks, although the implication may be for structural change, the focus is still on individual adaptation and movement through the hierarchy.

Aside from victim blaming, the Health Promotion Phase, with its emphasis on individual behavior change has many other flaws. It does not allow for many cultural deviations within the mainstream model. In our pluralistic society a philosophy which expects the same behaviors from different kinds of people does not acknowledge the various cultural mores and systems which operate in many urban centers in the United States. This approach also does not allow for economic disparity as it exists in the U.S. today. Virtually all of the behaviors espoused by the lifestyle change model require some level of economic affluence, from taking vitamins to gymnasium membership. Being healthy is synonymous with achievement of a position in the more affluent realm of society and depends greatly on the purchasing power of an individual. Whether the individual purchases direct services, products, or education, an economic interaction is almost always required for healthy behaviors to be in place. Even walking around one’s neighborhood obligates the individual to have the purchasing power to obtain housing within a safe locality where health status is not placed at risk when stepping outside of the home.

The health promotion approach does not call for comprehensive social change and often deters individuals from broader structural and environmental concerns. If the aforementioned scenario is considered, it is up to the individual to move away from the dangerous neighborhood, as opposed to working with neighborhood coalitions and government agencies toward the establishment of healthy communities. The fact that children raised in poor urban areas are still often exposed to lead poisoning, points to the low priority structural entities have placed on community health. This narrow approach to health status also results in competition and judgment on an individual level. People compete for health status in a number of arenas far beyond that of the athletic playing field. This competition for individual success through health status often deters from the more profound and enduring changes which can be achieved through government supported community efforts.

The diversity within our communities must be recognized as a positive attribute toward health access and status. In an effort to achieve a healthy status we must move beyond tolerance toward an embracing concern for the health of our communities and the individuals within. As our urban areas become increasingly diverse we must recognize that economic hardship is often much more than an individual problem, and that the health status and access playing field is far from equal. If we fail to address this issue, we will contribute to an ever expanding culture of poverty, wherein the rich heritage of the individuals of diverse populations is lost to the pressure of economic survival in the United States. When comparing two Orange County communities, for example, the difference becomes readily apparent. According to the U.S. Bureau of the Census, the poverty rate for Santa Ana is three times that of Irvine.

Approximately 1/3 of the homeless in the United States are children, and approximately 1/2 of the children of color are living near or below the poverty level. As the trend toward youthfulness and feminization of poverty continues, combined with the ever increasing numbers of poor female headed households, the chance for children to grow up healthy in the US becomes merely a distant hope. In the US today, 31.9% of African Americans live in poverty and 48% of single headed households are below the poverty level. This leads to decreased opportunities for education, health care, occupational status, and wellness. Poverty has been directly related, through numerous epidemiologic studies, to cancer, increased occupational risk factors, poor maternal/child health outcomes, diabetes, epidemics of
communicable diseases, greater cardiovascular disease 28-day mortality, and negative health behaviors, such as chemical use and unprotected sexual behavior.

Participation in public education often provides an individual with health education information. As increasing numbers of people leave the educational system prior to attainment of a high school diploma, fewer basic health behaviors will be practiced. A lack of education also impedes the opportunity for economic success, which then leads to poverty and suboptimal health status. A Latina female-headed family of a high school drop out has a 97% chance of living in poverty according to data from the US Bureau of the Census.

There are other factors which impede wellness in our communities, aside from the lack of education and increasing poverty rates. The paucity of health programs which attempt to provide care which is culturally and linguistically appropriate, as well as literacy level specific, is appalling. In the Los Angeles metropolitan area, Anglos are now the minority as Latinos represent 39% of the population. Asians/Pacific Islanders comprise the fastest growing minority population in the U.S. today. When examining the University of California at Irvine community, 64% of the students state that English is not their first language and the majority reside in Los Angeles County. As knowledge regarding the effectiveness of mind-body healing systems becomes more apparent, it is essential that health care providers acquire knowledge regarding the health beliefs and practices of the various cultures which comprise our communities. In addition, the need for literacy level and linguistically appropriate care and patient education is a vital component to insure accuracy of diagnosis and adherence to healthy behaviors. We must also develop health and wellness systems which counter violence within our communities.

Violence must be recognized beyond the traditional individualized problem of victim and criminal. The prevention of violence is a public health issue which needs to be addressed and supported by government and community efforts. Understanding the numerous factors which contribute to criminal behavior in our society mandates immediate response so that we can work toward preventing criminal development. Although competition and individualism have always been valued in the U.S., we must recognize the ways in which these two variables impede overall health status. In an effort to develop health and wellness care and outreach programs we must respect the communities at large. Society will be healthier if the following principles are addressed by all health professionals, educators, policy makers, and community advocates:

Participation and evaluation from communities must be acquired throughout all activities which are developed to promote health status and access; Linguistic issues must be addressed through methodology such as back translation; Literacy level-related issues must be addressed throughout all media development; Research must target specific and very homogeneous groups so as to learn as much as possible about the specific needs, behaviors, attitudes, and knowledge of the cultures of our communities. Thorough needs assessments of our communities’ health status and access issues must be conducted; Methods such as peer education programs must be implemented which leave knowledge and training within the community; Multiple forms of media should be utilized at all times; Practicing health professionals and educators need to engage in training regarding cultural competency.

As our globe becomes smaller, we must remember that optimal wellness cannot be achieved on an individual basis. Individualism and competition often impede the ability of diverse cultures to achieve maintenance of cultural pride and heritage. In fact, acculturation for many diverse populations has often proven to have a derogatory effect on health status and behavior. As our society becomes more multicultural, we must recognize that integration of culture is not a unidimensional process and that all peoples within the larger society can benefit greatly through the attainment of various cultural perspectives. Social structures, as opposed to individual behaviors, have always been the major causes of diseases. As Tesh (1989) states, “Whatever makes life better in general also makes it healthier.” If we continue to strive toward individual wellness without acknowledging the strength to be had by community based approaches to health, we will continue to sacrifice the greater whole for the lucky few.
CAREER CENTER

Career success depends on individual "wellness" emanating from a clear desire or goal orientation, appropriate career development behaviors, and excellent resources and support services.

A student's career "fitness" depends on their psychological and emotional conditioning; awareness and integration of personal values and ethics; positive connection to others (family, community, and friends); and intellectual and academic development. These dimensions of wellness are the underpinnings or building blocks that foster clarity of personal direction and result in vocational perspective and potential career success.

Career Development occurs throughout the span of one's college education and far beyond. The mission of the Career Center is to foster and promote career exploration and discovery as well as lifelong career management skills.

COUNSELING CENTER

Creating an Academic Community of Wellness: The Role of the Counseling Center

The diverse staff of the Counseling Center is committed to supporting the mission of the Student Affairs Division and the Counseling and Health Services cluster in its aim to create an academic community of wellness. Through a holistic orientation to mental health services, the Counseling Center strives to promote a strong mind and spirit in an effort to support the achievement of academic excellence. This holistic orientation impacts not only students, but the entire UCI campus community.

The Counseling Center operates in a proactive, developmental model to promote positive mental health and enhance student success. Among the various dimensions of the wellness construct, we are in a position to impact most directly the psychological/emotional dimension and the spiritual/values/ethics dimension. Since wellness is influenced by a number of psychological factors such as attitude and self-esteem, Counseling Center staff are uniquely qualified to contribute to the health and wellness of students and the campus community.

A holistic orientation to the creation of an academic community of wellness emphasizes the interconnectedness of body, mind, and spirit, as well as the individual and his/her family, community, and environment. Counseling and treatment plans where students take an active role in developing strategies on their own behalf are encouraged and valued. Counseling Center staff support and encourage a healthy and balanced lifestyle by teaching effective coping skills and drawing upon the power of supportive relationships in developing treatment plans.
HEALTH EDUCATION

A Note on Peer Pressure

Peer Pressure Might Be Good for You

The media continue to give peer pressure a negative label; blaming "it" for enticing youth to risky behaviors such as smoking and drug use. We have observed, however, that many students are influenced in positive ways by their peers and I wanted to share some of these observations with you.

Specific Challenges for New Students

New students are faced with immense challenges as they negotiate their first quarter of school. These challenges are well-documented in literature and include pressures to achieve academically, make new friends and maintain healthy behaviors (Douglas et al. 1997; Christie & Dinhm 1991; Tetenani et al. 1984). Wechsler et al. (2000) observed that while underage students drink less often, they drink more per occasion (putting them at higher risk for problems) and they are more likely to drink in private settings, one of the most difficult environments to influence via policy and enforcement. Establishing healthy and strong relationships early in an academic career could presumably contribute to a student's academic and personal success by promoting healthy social norms.

STUDENT HEALTH CENTER

Rather than just a medical clinic, the Student Health Center would like to be thought of as a Public Health facility for the UCI campus community. For we do more than just treating a cold or the flu, a sprained ankle or a tummy ache.

While the most visible of our functions is in the delivery of direct patient care, Student Health actively promotes a number of wellness measures. Top of the list is immunization, proven to be the most cost-effective preventative intervention in the history of medicine. Student Health offers most basic vaccines including MMR (measles, mumps and rubella),Td (tetanus and diphtheria), hepatitis B, A, and the new combined form, polio, meningococcal meningitis (menomune), influenza, etc. Student Health has played an active role in the screening for tuberculosis among the campus's entering students for years. We have also been in active partnership with the Orange County Health Care Agency in the tracking, testing and treatment of individuals following exposure to communicable diseases of public health concern, including tuberculosis and meningitis.

Student Health believes in mind and body wellness. Whereas a patient may present on the first visit with a physical complaint, our physicians are astute in detecting underlying emotional issues and will make appropriate, timely referral for psychological services. Our Mental Health professionals treat anxiety, depression, adjustment disorders, learning disabilities, addiction problems such as tobaccos and drugs, as well as major psychosis and the more common forms of eating disorders. Often our approach is multidisciplinary, involving a team of professionals including physicians, nurses, counselors, nutritionists as well as outside resources to bring about a patient's healing.
Acknowledgements

The publishing of this document would not be possible without the support of the following individuals and/or agencies:

* Dr. Norman Anderson and Virginia Cain, Office of Behavioral Sciences Research, National Institute of Health.

* Dr. Yolanda Moses, Dr. Britt Rios-Ellis, Dr. Joann Cannon, and our other symposium speakers.

* Dr. David Satcher, Surgeon General of United States.

To these people, the Counseling and Health Services cluster expresses its sincere gratitude and appreciation for helping UCI be “Fit for Excellence”.

Invitation

Visit the units of the Counseling and Health Services cluster:

**Career Center**
(949) 824-6881
Monday - Friday
8 am - 5 pm

**Health Education**
(949) 824-5806
Monday - Thursday
8 am - 5 pm
Friday 8 am - 4 pm

**Counseling Center**
(949) 824-6457
Monday - Friday
8 am - 5 pm

**Student Health Center**
(949) 824-5301
Monday - Friday
7:30 am - 5 pm
In November of 2001, Dr. David Satcher, Surgeon General of the United States, visited the campus of UCI. During his Chancellor's Distinguished Lecturer Address, Dr. Satcher discussed a number of health promotion and disease prevention efforts. In doing so, he left us a prescription for a healthy lifestyle. We, in turn, would like to pass it on to you, in the hope that you can incorporate these recommendations into your life.

- Moderate physical activity, at least 5 days per week for thirty minutes per day.
- Eat at least five servings of fruits and vegetables per day.
- Avoid toxins such as tobacco, illicit drugs, and abuse of alcohol.
- Responsible sexual behavior with abstinence where appropriate.