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REVIEW

The Evolution of Wellness Models: Implications for Women's Health and Well-Being

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Abstract: The concept of wellness goes beyond the traditional definition of health, representing a holistic and evolving spectrum that combines lifestyle choices with health-related behaviors. A systematic search was performed across Web of Science, Scopus, Medline, and PubMed, covering all published articles till 2024. From an initial pool of 1619 papers 12 met the inclusion criteria. The review identified thirteen wellness frameworks, analyzing their aspects and importance for women's health. These models span from fundamental frameworks, such as Dunn's High-Level Wellness, to more modern paradigms, like Kauppi's Wellness Consensus Model. Numerous deficiencies were discerned during the examination, especially concerning cultural pertinence and empirical substantiation. Many prevailing models are entrenched in Western frameworks, constraining their universal applicability, particularly in non-Western environments. Additionally, considerations that are specific to gender, such as reproductive health, caregiving duties, and the equilibrium between professional and personal spheres, are frequently neglected in these models, thereby impeding their efficacy in addressing the distinct wellness challenges confronted by women. The results underscore the pressing necessity for formulating more inclusive wellness frameworks sensitive to gender and adaptable to diverse cultural contexts. Such models would better meet women's holistic health requirements by recognizing the varied social, cultural, and economic influences that affect their overall well-being. This study enriches the ongoing dialogue regarding wellness by advocating for a trajectory toward more comprehensive and representative wellness models for women across various global contexts.

Keywords: women's wellness models, gender-specific wellness, cultural, theories, holistic wellness

Introduction and Background

Health, wellness, and well-being are interrelated yet distinct concepts defined and measured differently across various contexts. Clarifying these distinctions can help create a more targeted and holistic approach to health promotion and well-being. Investigating the three concepts from the literature, we can state that health is focused on the absence of disease and the presence of physical, mental, and social well-being. Wellness emphasizes active engagement and personal responsibility in achieving a balanced and fulfilling life; on the other hand, well-being centers on subjective experiences of happiness and life satisfaction.[1–4] This study introduces a tree metaphor developed by the author to conceptualize the interconnected dimensions of health, wellness, well-being, and flourishing., as shown in Figure 1. The figure illustrates health as the roots, symbolizing foundation and stability, while wellness is depicted as the trunk and branches, representing growth and balance. Well-being, represented by the fruit, reflects fulfillment and flourishing. This tree metaphor highlights how health and wellness nurture well-being and lead to a flourishing life.

The growing recognition of wellness as a critical factor in bettering health outcomes incorporates physical, mental, and social elements of well-being. The term wellness signifies a broad and complex idea that exceeds the simple definition of health, stressing an ongoing process of well-being that merges lifestyle preferences with health-related habits. This all-encompassing methodology is increasingly gaining prominence across diverse contexts, enhancing the quality of life and health outcomes through various wellness paradigms. A recently published definition of wellness by Eriksson et al (2024) stated, "a holistic and multidimensional concept represented on a continuum of being well that goes beyond health."[5]

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Figure 1 Tree metaphor to illustrate how health, wellness, and well-being are interconnected.

Theories play a crucial role in understanding wellness by providing frameworks that integrate psychological, social, and physiological dimensions of well-being. Conceptual wellness modules have evolved over the years. Understanding wellness theories and models has significantly advanced by developing various theoretical frameworks that integrate well-being dimensions.[6–8] Theoretical frameworks act as the structural backbone of research, guiding the inquiry process and ensuring coherence from conception through analysis.[9]

A recent systematic review was published in 2023 that assesses the structures and domains of wellness models. They aimed to categorize and evaluate various wellness frameworks, identifying standard components and dimensions across models. This research is valuable, but it does not explicitly address cultural or gender-specific aspects. Additionally, the review included research tools that are not focused on wellness theories or models, and it incorporated some well-being theories, which differ in definition and measurement from wellness. These limitations highlight the need for further research that develops culturally specific wellness models, particularly for women.[10] Two other published papers about wellness theories only present it chronologically without examining whether these models have been empirically validated. While the chronological review provides a historical perspective, it lacks a critical analysis of the validity and applicability of the models in contemporary contexts.[11,12] This study aims to systematically review and synthesize existing wellness theories and models, focusing on evaluating their validity and application in studies involving women. The lack of comprehensive wellness models for women is concerning. Frameworks that exist fail to incorporate gender-specific issues, including sociocultural norms, familial obligations, and health inequities. Bridging this gap is essential for promoting holistic health initiatives that cater to women's wellness. This review concentrates on the wellness needs of adult women, despite the importance of adolescence. Future studies should investigate adolescent wellness frameworks to enhance these insights.

The study is structured around four main objectives. First, it aims to systematically identify and catalog existing wellness theories and models without imposing any time frame restrictions, allowing for a comprehensive exploration of historical and contemporary models. Second, the study critically evaluates the relevance and applicability of these models by examining key elements such as the developer, the date of inception, the country of origin, the intended population, the wellness dimensions addressed, and the gender-specific applicability of each model. Third, the study assesses the validation of each theory or model by reviewing whether the original author provided a testable measure or instrument and by examining cited papers that discuss the reliability and validation of these models in subsequent studies. Finally,

the study seeks to reflect on gaps in the current models and provide a foundation for developing a wellness model specifically tailored to the unique needs of women.

Methodology

This systematic review follows the guidelines established by Tawfik et al (2019),[13] which recommend that the first step in conducting a systematic review is to develop clear research questions and objectives using either the SPIDER or PICO frameworks. I chose SPIDER since PICO is commonly used in clinical studies to compare interventions and outcomes. SPIDER facilitates the exploration of different populations, phenomena of interest, research designs, evaluation criteria, and research types, which align well with the goals of this review. The research question developed as follows: What populations are studied, what methods and interventions are used, what research designs are employed, how is effectiveness evaluated, and what types of research are conducted in the studies of wellness models and measures worldwide? The spider breakdown is illustrated in the Figure 2:

The second step is to define the inclusion and exclusion criteria. The inclusion criteria for this systematic review is to include studies involving diverse adult populations from various demographics (age, gender, socio-economic status) worldwide, excluding disease-specific or context-specific studies. We focus on research using well-defined methods and interventions related to physical, mental, social, and occupational wellness. Eligible research designs include qualitative, quantitative, and mixed-methods studies. Theoretical and conceptual papers that propose or discuss wellness models.

Exclusion Criteria include studies focusing on children, adolescents, or niche populations and those using systematic reviews, meta-analyses, or randomized control trials (RCTs). Articles lacking precise methods, poor-quality research designs, or irrelevant to wellness (eg, medical treatments) are excluded.

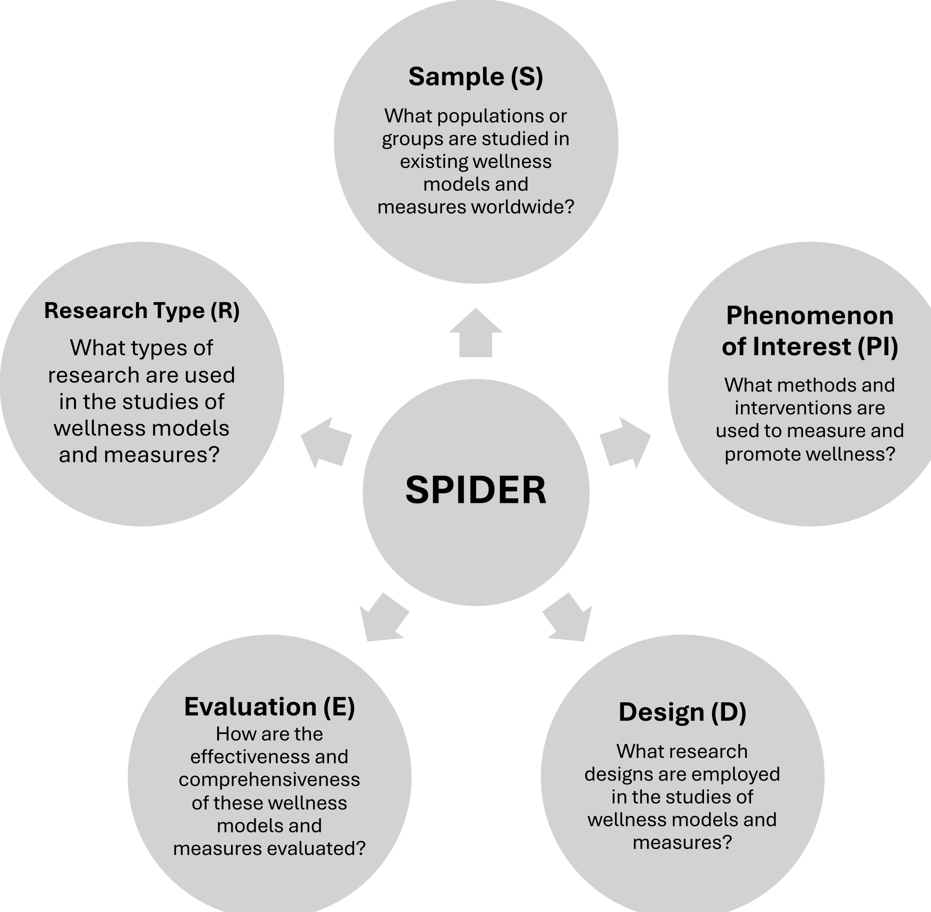

Figure 2 SPIDER breakdown of the research aim.

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The third step involved developing a proper search strategy. I collaborated with the librarian to pilot the search strategy and ensure the use of appropriate MeSH terms. To organize the review process, I utilized the ***PRISMA 2020 flow diagram*** for new systematic reviews, which included searches across databases, registers, and other relevant sources, as shown in Figure 3. This method ensured a comprehensive and systematic identification and selection of studies. The final developed search strings are shown in Table 1. The systematic search was conducted up to 2024 across Web of Science, Scopus, Medline, and PubMed. The search strategy focused on terms related to wellness models, women's health, and multidimensional wellness frameworks.

The fourth step is to screen the data. The 1619 paper has been exported to Zotero to check for duplication. 850 references were duplicated, and 769 were moved to Rayyan's application. **Rayyan** is a web and mobile application designed to facilitate the process of screening and selecting studies for systematic reviews.[15] In Rayyan, the screening process consisted of two stages. Initially, 769 papers were included for another duplication checking, and after resolving 8 duplicates (4 of which were deleted), 765 papers moved forward. In the second stage, the titles and abstracts of the 765 papers were screened, resulting in 108 papers being included. Using Rayyan's "compute rating" feature for further validation, the final count was reduced to 44 included papers. A total of 721 papers were excluded due to wrong outcomes, wrong population, or incorrect study design.

Rayyan's "compute rating" feature uses machine learning to help researchers prioritize studies during the screening process. It automatically suggests ratings for papers by analyzing their content based on previous user decisions, assisting researchers in determining which studies to include or exclude. This feature helps streamline the review process by offering AI-driven recommendations, saving time in the decision-making phase. The researcher made the final decision.

The fifth step involved reviewing the full text of the 44 papers to determine if they met the inclusion criteria. Of these, 37 were excluded due to wrong outcomes, and 6 focused on the wrong population, such as the elderly or young individuals. Only one paper discussed a wellness model. Additionally, the researcher identified 21 studies from other sources: 2 from organizations, 13 from citation searching, and 6 from books, after excluding 10 reports that used survey instruments instead of theories or models. 12 Articles will be used to answer the research question for this systematic

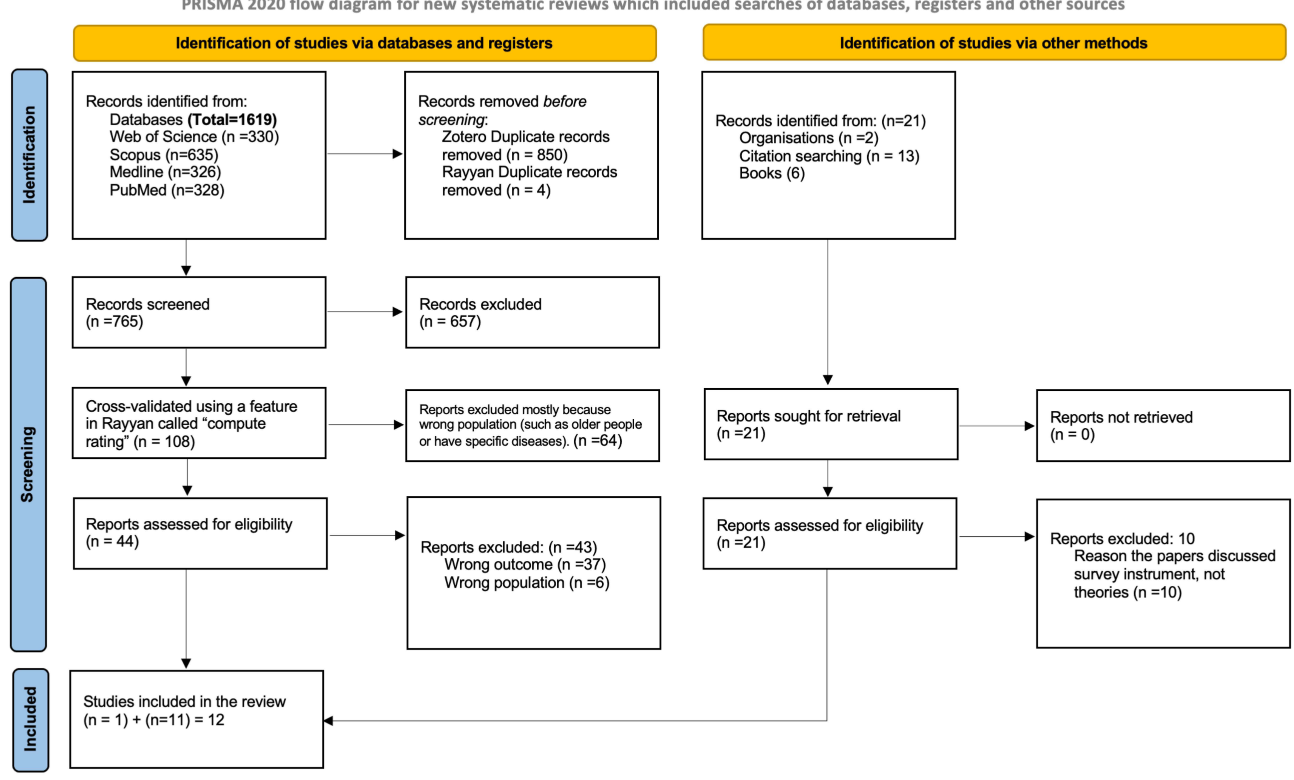

Figure 3 PRISMA flowchart.

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Table 1 Database Searched and Syntax

Database	Search String (Syntax)	Number of Papers
Web of Science	TI=("Wellness" OR "Well-being" OR "Wellbeing" OR "Optimal Health" OR "Optimal wellness") AND TI=("Model" OR "Theory" OR "Framework" OR "Dimensions" OR "Components") AND TS=(Adult* OR Young*)	**330**
Scopus	TITLE(("Wellness" OR "Well-being" OR "Wellbeing" OR "Optimal Health" OR "Optimal wellness") AND ("Model" OR "Theory" OR "Framework" OR "Dimensions" OR "Components")) AND TS=(Adult* OR Young*)	**635**
Medline	TS=(("Wellness" OR "Well-being" OR "Wellbeing" OR "Optimal Health" OR "Optimal wellness") AND ("Model" OR "Theory" OR "Framework" OR "Dimensions" OR "Components")) AND TS=(Adult* OR Young*)	**322**
PubMed	(("Wellness"[Title] OR "Well-being"[Title] OR "Wellbeing"[Title] OR "Optimal Health"[Title]) OR "Optimal wellness"[Title]) AND ("humans"[Filter] AND "English"[Filter]) AND ("Model"[Title] OR "Theory"[Title] OR "Framework"[Title] OR "Dimensions"[Title] OR Components [TITLE]))	**328**
Total	**1619**	

review. The systematic review included three authors who each assessed the abstracts and the full texts of the studies without collaboration. Initial screening excluded studies that did not satisfy the inclusion criteria. Full-text screening confirmed the eligibility of the remaining studies. At least two authors assessed every article to achieve consistency and curtail bias. Discrepancies regarding inclusion were discussed and resolved through consensus. If conflicts persisted, a third author was the arbitrator for the final decision.

The sixth stage involves data extraction and quality assessment. An Excel sheet to systematically record relevant information was developed, including theory name, developer, date, country, journal, population (age and gender), a description of the theory, the number of dimensions, the specific dimensions, citations, limitations, recommendations, R^2 values, and whether the theory addresses women. This structured approach ensures all critical details are captured for analysis, allowing for a comprehensive comparison of the wellness models and their applicability, particularly to women. The synthesis utilized a narrative approach. Data were categorized by themes, including wellness dimensions, target populations, and relevance to women. A comparative analysis of the models revealed trends, gaps, and strengths, facilitating an in-depth evaluation of wellness frameworks.

Since the studies identified in this review were neither quantitative nor qualitative, the author developed a Theoretical or Conceptual Models Quality Assessment Tool to evaluate the included models systematically. This tool assessed clarity and coherence, relevance to women's wellness, inclusivity of key wellness dimensions (eg, emotional, social, physical), and empirical or theoretical basis. Models were scored as high, medium, or low quality across these criteria, providing a standardized and transparent framework for comparing their comprehensiveness and applicability to the study's objectives. The 7th and the 8th steps will be reflected in the result and discussion section.

Result

Model and Theories and the Number of Dimensions

In the wellness literature, various frameworks were proposed to encompass different dimensions that significantly impacted individuals. The evolution of wellness theories reflects a growing understanding of health as a multidimensional concept- encompassing various aspects of human well-being. In this literature review, 13 key models reflecting diverse approaches to holistic well-being will be presented chronologically, starting with Dunn, (1959b) **High-Level Wellness**, which is foundational in the wellness movement, emphasizing that wellness is not just the absence of illness but a dynamic process of growth and achieving one's fullest potential within the context of an ever-changing environment it consists of Physical Wellness (Body), Mental Wellness (Mind), Spiritual Wellness (Spirit).[16] In 1972, the father of wellness developed the **Illness-Wellness Continuum**. Dr. John Travis 1972 introduced the idea that health exists on a spectrum from illness to wellness. It emphasizes that health is not just the absence of disease but involves achieving a high level of overall well-being.[17]

However, the model's linear approach, which places illness and wellness at opposite ends, may not fully capture the complexity of wellness as we understand it today. Modern interpretations of wellness recognize that it is multidimensional and that individuals can experience high levels of wellness in some areas of their lives, even if they are managing chronic illness or other health challenges.

After three years, Bill Hettler, one of the key pioneers in wellness, introduced the Six Dimensions of Wellness model in 1976. Now, it is called the **NWI's Six Dimensions of Wellness**. The dimensions are Emotional Wellness, Physical Wellness, Intellectual Wellness, Occupational Wellness, Spiritual Wellness, and Social Wellness.[18] Don Ardell built upon Dunn's ideas in the 1970s but expanded the **High-Level Wellness Model**, where he defined wellness as a choice to take responsibility for the quality of one's life. It has five dimensions: self-responsibility, Nutritional Awareness, Physical Fitness, Stress Management, and Environmental Sensitivity.[6]

Travis overcame the issue of his Illness-Wellness Continuum model; in 1977, he introduced the **Wellness Energy System concept**. The module views human wellness as an energy system where efficient energy flow is crucial to maintaining health. The system consists of 12 key life processes, which serve as inputs and outputs. These processes collectively contribute to the individual's overall energy balance, influencing their wellness.[17]

Building on these ideas, Travis developed the **Multidimensional Wheel of Wellness in 2002**. This graphical presentation of the Wellness Energy System's foundational ideas offers a more structured and visually accessible model, and these 12 Key Life Processes are not dimensions of wellness.

In 1979, Lafferty introduced the **Total Person Concept**, a holistic approach integrated multiple aspects of wellness. The model incorporates five key dimensions: emotional, intellectual, physical, social, and spiritual wellness, emphasizing the interconnection of these areas in achieving overall well-being.[8] The **Wheel of Wellness** model by Witmer & Sweeney in 1991 presented five key interrelated life tasks, with the core of spirituality as the center of the well. The tasks are spirituality, self-direction, work and leisure, friendship, and love. The framework encompassed twelve subtasks. The Wheel was framed as a circumplex, with spirituality positioned at the center as a well-adjusted individual's paramount and most vital attribute. The elements of self-direction are conceptualized to function in a manner comparable to the spokes of a wheel.[19]

Later, in 1997, Adams et al developed the **Perceived Wellness Model**, which emphasizes six dimensions: Physical Wellness, Spiritual Wellness, Intellectual Wellness, Psychological Wellness, Social Wellness, and Emotional Wellness.[20] Adams's dimensions of wellness were similar to Lafferty's, but he expanded the model by adding psychological wellness as an additional dimension, providing a more comprehensive approach to understanding well-being.

Montague et al introduced the vocational dimensions to the other main dimensions introduced in the literature in 2002. The model was named the **Whole-Person Wellness Model**.[21] Later, in 2004, Myers and Sweeney developed an **Indivisible Self-Model** based on Adlerian principles. The model identified the "Indivisible Self" as central to overall wellness and consisted of five major factors, further breaking down into 17 wellness subfactors.[22]

The **Integrated Model of Wellness** by Lauren J. Roscoe continued this holistic approach by emphasizing wellness as a balanced state. The model consisted of seven dimensions: social, emotional, physical, intellectual, spiritual, occupational, and environmental.[23]

Moreover, the **Eight Dimensions of Wellness Model** (2009) emphasized a holistic approach to wellness through eight dimensions. Stoewen's model promoted a balanced integration of these dimensions, encouraging personal harmony rather than emphasizing each aspect equally.[24] Swarbrick's model has evolved over the years, as shown in Figure 4.

The **Wellness Consensus Model** developed by Krista Kauppi et al in 2023 aimed to create a unified approach to measuring wellness by combining insights from Finnish and international expert panels. The model identified ten essential domains for wellness, including Mental Health, Cognitive Health, Exercise, Nutrition, Community, Life Satisfaction, Meaningfulness, Work-Life Balance, Social Networks, Self-Care, and Lifestyle Habits. Although comprehensive, the model has not yet been validated, making it a conceptual framework pending further empirical testing.[10]

When evaluating wellness models, it is essential to consider the context in which they were developed, including the country of origin, the research design, the population they were designed for, and whether they account for gender-specific factors. First, the country of origin can influence the cultural context in which the model was developed. For example, Western models may emphasize individualism and self-reliance. In contrast, models designed in non-Western

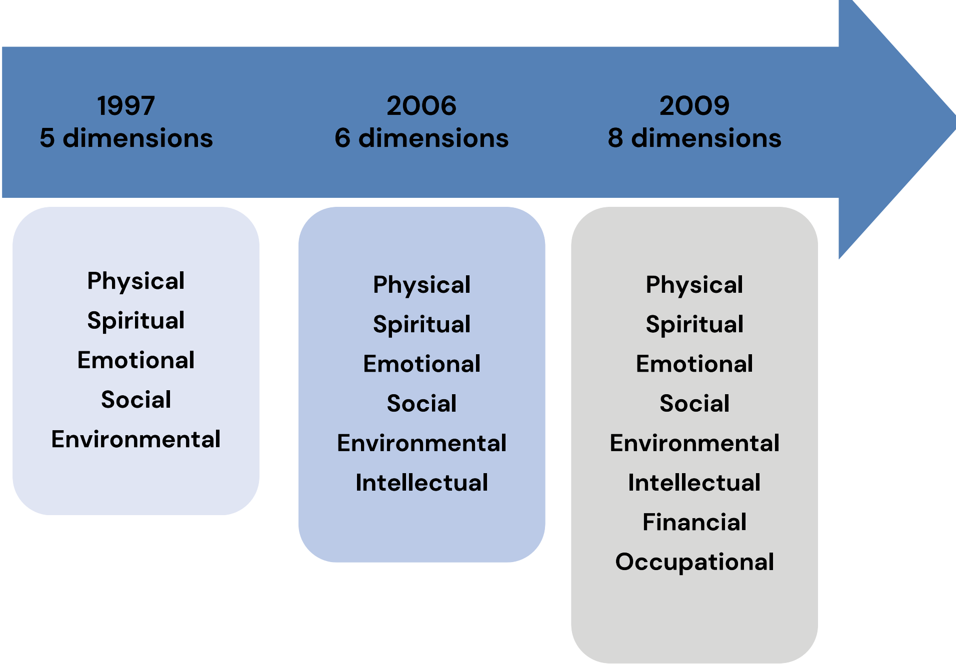

Figure 4 Swarbrick Model Evolution.

contexts may highlight communal well-being and social support systems. Most of the models presented here were developed in the USA, and two were developed in Finland.

Secondly, regarding the research design, most papers were conceptual framework papers not supported by a research tool and validation of the model. Thirdly, in terms of the target population. For instance, models like NWI's Six Dimensions of Wellness may be more general and designed for various populations. In contrast, other models may focus on specific groups such as employees, students, or retirees. Thirdly, regarding gender, some wellness models may be designed to address gender-specific issues, while others may be more general. Most of the discussed wellness models did not discuss gender type and did not consider women-specific dimensions.

After discussing the foundational theoretical framework within the literature, it is clear that several key features characterize wellness: holistic, encompassing multiple dimensions; it focuses on lifestyle behaviors; it is action-oriented, involving processes and practices; and it acknowledges the interrelatedness between the individual and their environment.[25]

In conclusion, these theories collectively highlight the complexity and evolving understanding of wellness as a dynamic and multifaceted concept. Comparatively, these models vary in the number and scope of wellness dimensions they incorporate, ranging from 3 dimensions in the Dunn model to 12 in the Travis framework, with others incorporating life task processes rather than dimensions. Most models have been developed in the United States, and two of them have been developed in Finland. This showcases the increasing complexity of wellness models over time, as shown in Table 2, which shows the different theories and their dimensions.

Comparison of Wellness Models and Theories Across Key Wellness Dimensions

The matrix provided a comparative overview of the 13 wellness models identified in the literature, evaluated based on the SPIDER criteria. One model that only discussed health and wellness without discussing the dimensions was removed from the matrix, as shown in Table 3. The physical wellness dimension is covered by almost all models, underscoring its foundational role in overall wellness. However, the Wellness Energy System did not explicitly address this aspect in the comparison; it was stated as "Moving." Emotional and psychological wellness were critical components in most models, such as the Wheel of Wellness and Perceived Wellness, highlighting their central importance to well-being. However, a few models, like the Total Person Concept, did not emphasize psychological wellness.

Table 2 Theories Identify Through the Systematic Review With the Number of Dimensions Arranged Chronologically

#	Theories	Developer	Date	Country	Publisher	Number of Dimensions	Dimensions	Population Age	Gender
1	High-Level Wellness[7]	Halbert L. Dunn	1959	USA	Canadian Journal of Public Health	**3**	Physical Wellness (Body) Mental Wellness (Mind) Spiritual Wellness (Spirit)	General population, no specific age mentioned	No gender specified
2	Illness-wellness continuum[17]	Dr. John Travis	1972	USA	Clarkson Potter/Ten Speed	2	It did not reflect dimensions rather it shows the relationship between illness and wellness.	General population, no specific age mentioned	No gender specified
3	NWI's Six Dimensions of Wellness[18]	Dr. Bill Hettler,	1976	USA	National Institute of Wellness	6	Emotional Wellness Physical Wellness Intellectual Wellness Occupational Wellness Spiritual Wellness Social Wellness	General population, no specific age mentioned	No gender specified
4	High Level Wellness[7]	Don Ardell	1977	USA	National Institute of Wellness	5	Self-Responsibility Nutritional Awareness Physical Fitness Stress Management Environmental Sensitivity	General population, no specific age mentioned	No gender specified
5	Wellness Energy System[17] "Multidimensional Wheel of Wellness"	Dr. John Travis	1977	USA	Clarkson Potter/Ten Speed	12	Self-Responsibility & Love Breathing & Relaxing Sensing, Eating Moving, Feeling Thinking Playing & Working Communicating,Intimacy Finding Meaning Transcending	General population, no specific age mentioned	No gender specified
6	Total person concept[8]	Lafferty	1979	USA	*Health Education* Journal	5	Emotional,Intellectual, Physical, Social, and Spiritual.	No specific age mentioned	No gender specified
7	Wheel of wellness[19]	T. J. Sweeney and J. M. Witmer	1991	USA	Journal of Counseling & Development	5	Spirituality, Self-Direction Work Friendship Love	General population, no specific age mentioned	No gender specified
8	Perceived wellness[20]	Troy Adams, Janet Bezner, Mary Steinhardt	1997	USA	American Journal of Health Promotion	6	Physical Wellness Spiritual Wellness Intellectual Wellness Psychological Wellness Social Wellness Emotional Wellness	Mixed adults, including employees and students	Male and Female
9	Whole-Person Wellness Model[21]	Montague, Joy, Bailey, and Koenig	2002	USA	Assisted Living Consult	6	Emotional Wellness Physical Wellness Intellectual Wellness Vocational Wellness Spiritual Wellness Social Wellness"	Primarily older adults in assisted living and long-term care settings	No gender specified

(*Continued*)

Table 2 (Continued).

#	Theories	Developer	Date	Country	Publisher	Number of Dimensions	Dimensions	Population Age	Gender
10	Indivisible self model[22]	Myers and Sweeney	2004	USA	Journal of Individual Psychology	5	Creative Self Coping Self Social Self Physical Self Essential Self	General population, no specific age mentioned	No gender specified
11	Integrated model of wellness[23]	Lauren J. Roscoe	2009	Finland	Journal of Counseling & Development	7	Social Wellness Emotional Wellness Physical Wellness Intellectual Wellness Spiritual Wellness Occupational Wellness Environmental Wellness	General population, no specific age mentioned	No gender specified
12	Eight Dimensions of Wellness Model[24]	Swarbrick	2009	USA	Oxford University Press	8	Physical Wellness Intellectual Wellness Emotional Wellness Social Wellness Spiritual Wellness Vocational Wellness Financial Wellness Environmental Wellness	Adult	No gender specified
13	Wellness Consensus Model[26]	Krista Kauppi, Eira Roos, Patrik Borg, and Paulus Torkki	2023	Finland	American Journal of Health Promotion	10	Mental Health, Cognitive Health, Habits Exercise, Nutrition Community, Life Satisfaction Meaningfulness, Work-Life Balance, Social Networks Self-Care and Lifestyle	Not specified	No gender specified

Social wellness was covered by about half of the models, including NWI's Six Dimensions, Perceived Wellness, and the Eight Dimensions of Wellness Model, which indicated its moderate significance across wellness frameworks. At the same time, intellectual wellness was addressed less frequently but was included in models like NWI's Six Dimensions and the Wheel of Wellness. Similarly, occupational wellness is highlighted by only a few models, such as NWI's Six Dimensions, suggesting that work-life balance is not universally considered essential to wellness. Environmental wellness was rarely covered, with only the eight dimensions of wellness, the integrated model of wellness, and the high level of wellness addressing it. Likewise, the financial dimension is explicitly covered only by the Eight Dimensions of Wellness. Self-regulation and responsibility were significant components in models like Travis & Ryan's Illness-Wellness Continuum and the Wheel of Wellness, which emphasized personal responsibility for wellness. Nutrition and eating were referenced but not widely covered, with models like Ardell's High-Level Wellness and the Wellness Consensus Model incorporating these elements. Aspects such as coping, essential self, and cognitive health were less frequently addressed, although models like Perceived Wellness and the Indivisible Self Model explore these life processes.

Life satisfaction and meaningfulness appear only in the Wellness Consensus Model, indicating that not all frameworks prioritize subjective well-being and purpose. Spiritual wellness was a notable dimension in several models, including the Wheel of Wellness, Perceived Wellness, and Whole-Person Wellness, reflecting its importance in a holistic view of wellness.

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Table 3 Comparison of Wellness Models and Theories Across Key Wellness Dimensions

Theories	**High-Level Wellness (3)**	**NWI's Six Dimensions of Wellness (6)**	**High Level Wellness (5)**	**Wellness Energy System (The Multidimensional Wheel of Wellness) (12)**	**Total person Concept (5)**	**Wheel of wellness (5)**	**Perceived wellness (6)**	**Whole-Person Wellness Model (6)**	**Indivisible self model (5)**	**Integrated Model of Wellness (7)**	**Eight Dimensions of Wellness Model (8)**	**Wellness Consensus Model (10)**
Citation	(Dunn, 1959)	(Hettler, 1976)	(Ardell, 1977)	(Travis & Ryan, 2004)	(Lafferty, 1979)	(Witmer & Sweeney, 1992)	(Adams et al 1997)	(Montague & Frank, 2007)	(Myers & Sweeney, 2004)	(Roscoe, 2009)	(Swarbrick, 2012)	(Kauppi et al 2024)
Physical	*	*	*	* **Moving**	*		*	*	*	*	*	**Exercise**
Mental	*						**Psychological**					*
Spiritual	*	*			*	*	*	*		*	*	
Emotional		*		* **Feeling**	*		*	*		*	*	
Intellectual		*			*		*	*		*	*	
Occupational		*				**Work**				*	*	
Social		*		***Communicating**	*		*	*	*	*	*	*
Environmental			*							*	*	
Financial											*	
Vocational								*				
Self-Responsibility			*	*		*						
Nutritional Awareness			*	* **Eating**								*
Stress Management			*									
Friendship						*						
love				*		*						
Creative Self									*			
Coping Self									*			
Essential Self									*			
Cognitive Health				* **Thinking**								*

Community												*
Life Satisfaction												*
Meaningfulness												*
Work-Life Balance				* **Playing & Working**								*
Self-Care and Lifestyle Habits												*
Breathing & Relaxing				*								
Sensing				*								
Intimacy				*								
Finding Meaning				*								
Transcending				*								

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Validity and Reliability of the Wellness Models

In this section, a systematic comparative examination of diverse conceptual frameworks about wellness emphasizes their reliability and validity, as shown in Table 4. It examines the extent to which the original authors or subsequent researchers have empirically validated these models. While some models, like Perceived Wellness, have undergone rigorous testing and demonstrate strong reliability and validity, others lack empirical support. This analysis highlights gaps in validating several wellness models, underscoring the need for further research to ensure their robustness and applicability in diverse contexts.

The matrix analyzes the reliability and validity of various wellness models and theories, highlighting empirical evidence, citations, and external research usage. A key finding is that while some models have been validated by the original authors, others lack empirical validation or have not been explicitly tested for reliability and validity.

Models like Dunn's High-Level Wellness (1959) have been widely cited and validated through various studies.[7] Only one research Mantsos et al (2024) work reported reliability scores (Body 0.86, Mind 0.95, Spirit 0.94), and discriminant validity has been confirmed through the Average Variance Extracted (AVE), with each factor meeting acceptable validity thresholds.[28] Similarly, NWI's Six Dimensions of Wellness shows good reliability Cronbach's alpha of 0.847) and validity across specific populations, such as women and the elderly.[29,30] On the other hand, models like Ardell's High-Level Wellness (1977) and Travis & Ryan's Wellness Energy System (2004) show no evidence of empirical validation for either reliability or validity. Despite being cited by many researchers, no tests for reliability or validity have been reported by their original authors or other researchers.[6,17]

The Wheel of Wellness by Witmer & Sweeney, (1992) is another well-cited model with robust validation. It has undergone structural equation modeling (SEM) with an RMSEA of 0.042, which shows a good model fit and high-reliability Cronbach alpha 0.7.[31] Additionally, Perceived Wellness has been validated by the authors themselves; it demonstrated evidence of convergent validity (r = 0.37 to 0.56) and internal consistency (a = 0.89 to 91). Moreover, it has been thoroughly validated, with a high Cronbach's alpha (>0.7) across different studies, and its construct validity and convergent validity have been confirmed in various contexts, such as in Iranian and African populations.[20,32–34]

In contrast, models like the Whole-Person Wellness Model and the Integrated Model of Wellness show no reported reliability or validity data or empirical validation from the authors. Though these models are cited in the literature, the lack of concrete empirical testing raises questions about their robustness.[21,23]

The Indivisible Self Model has been validated regarding its reliability, with Cronbach's alpha ranging from 0.58 to 0.82 across various factors. Exploratory factor analysis and root mean square of approximation (RMSEA) values of 0.07 indicate a good fit between the model and the data, making it one of the few models with clear empirical support.[22] Moreover, it has been validated by other authors.[25,35]

Lastly, the Eight Dimensions of Wellness and the Wellness Consensus Model are relatively new.[24,26] Swarbrick & Yudof (2017) was validated first by Das 2015 who reported a Cronbach alpha for all items 0.97 and KMO= 0.949; 2 (5460) = 343,336.007, $p < 0.001$ in undergraduate psychology students (n = 517).[36] Later, in 2024, Swarbrick published a paper discussing the Factor Structure, Reliability, and Construct Validity of the Wellness Inventory.[27] Kauppi's Wellness Consensus Model was created using the Delphi technique, but it has yet to undergo rigorous empirical testing.

Discussion and Conclusion

The systematic investigation undertaken in this study provides a comprehensive evaluation of existing wellness models, identifying their relevance and applicability to women's wellness needs. This paper highlights critical gaps and strengths in the current frameworks by examining the origin, demographic focus, dimensions addressed, and validation processes of these models. These insights lay the groundwork for developing a culturally inclusive, women-specific wellness model that addresses diverse challenges and needs.

After we have discussed the 13 models, it is imperative to consider the contextual factors surrounding their creation, encompassing their nation of origin, the intended demographic, and the applicability concerning gender-specific issues. Most models analyzed, such as Dunn's High-Level Wellness and Hettler's Six Dimensions of Wellness, were conceived in the United States, a context that may underscore the values of individualism and self-sufficiency. These frameworks

Table 4 Reliability and Validity of the Wellness Models

Model	Cited	Reliability and Validity			
High-Level Wellness[7]	Cited by 872	(Mantsos et al 2024) Reliability Body (0.86), Mind (0.95), and Spirit (0.94) Convergent validity: The average variance extracted (AVE) values exceeded 50% for all subscales Discriminant validity: The square root of AVE for each factor was higher than its correlation with other factors, ensuring sufficient discriminant validity			
NWI's Six Dimensions of Wellness[18]	NA report	(Al Awar et al 2022) Cronbach's alpha of 0.847 among Women	(Slivinske et al 1996) reliability 0.75 to 0.94. Validity r2=0.32 among elderly		
High Level Wellness[7]	Cited by 756	There is no evidence of reliability and validity			
The Multidimensional Wheel of Wellness[17]	Cited by 165	The wellness inventory was developed by Travis but there is no evidence of reliability and validity			
Total person concept[8]	Cited by 83	(Renger et al 2000) (Cronbach's alpha) from 0.78 to 0.95 across the dimensions R= 0.42 to 0.75			
Wheel of wellness[19]	Cited by 970	(Hattie et al 2004) Cronbach alpha 0.7 structural equation modeling (SEM) show acceptable RMSEA of 0.042.			
Perceived wellness[20]	Cited by 818	(Kaveh et al 2016) alpha >0.7 represents acceptable reliability, The Content Validity Ratio (CVR) as 0.84. and the construct validity of the test. Was ranging from R= 0.42 to 0.68 This was acceptable in Iranian context	(Adams et al 1997) Perceived Wellness Survey demonstrated evidence of convergent validity (r = 0.37 to 0.56) and internal consistency (a = 0.89 to.91).	(Rothmann & Ekkerd, 2007) Cronbach's alpha, ranged from 0.81 and exploratory factor analysis, with Tucker's phi coefficients of 0.98 among African policeman	(Harari et al 2005) Cronbach's alpha of 0.91, validity R range between 0.53 to 0.70
Whole-Person Wellness Model[21]	NA report	(Yamashita et al 2022) The study used the model but did not report any reliability and validity test			

(*Continued*)

https://doi.org/10.2147/IJWH.S498027

Table 4 (Continued).

Model	Cited	Reliability and Validity			
Indivisible self model[22]	Cited by 560	(Rachele et al 2014) among adolescent female aged 12–14 otal wellness score and the five dimension summary scores remained comparatively stable between assessments	(Myers & Sweeney, 2004) but they created the Five Factor Wellness Inventory root mean square error of approximation (RMSEA) were used to assess model fit, with an RMSEA of 0.042 indicating an acceptable fit of the model to the data	(Els & Rey, 2006) Cronbach's alpha coefficients ranged from 0.58 to 0.82 for various factors. The Root Mean Square Error of Approximation (RMSEA) value of 0.07 indicated a good fit between the model and the data	
Integrated model of wellness[23]	Cited by 583	There is no evidence of reliability and validity			
Eight Dimensions of Wellness Model[24]	Cited by 46	(Das, 2015) reported an cronbach alpha for all item 0.97 and KMO= 0.949; c2 (5460) = 343,336.007, p < 0.001 Undergraduate psychology students (n = 517)	Swarbrick & Yudof, 2017 have developed a research tool validated in November 2024.[27]		
Wellness Consensus Model[26]	Cited by 2	It is new developed model using delphi technique, There is no evidence of reliability and validity			

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may require modification to suit non-Western cultural paradigms, wherein communal wellness and social support structures hold greater significance.

Within the wellness literature, various frameworks have been proposed to encompass the diverse dimensions that significantly impact individuals' overall well-being. The evolution of wellness theories reflects a growing understanding of health as a multidimensional concept encompassing various aspects of human well-being. The analysis of 13 wellness models, from Dunn, (1959)[16] High-Level Wellness to more contemporary approaches, concludes with the Wellness Consensus Model by Kauppi et al (2024).[26] Focused on evaluating whether they address the foundational dimensions of health physical, social, and emotional/mental/psychological wellness critical to comprehensive well-being. This approach ensures that the models are assessed for their ability to meet the most essential aspects of human wellness, particularly as they relate to women's unique needs. Beyond these foundations, we also explore whether the models incorporate broader dimensions of wellness, such as cultural, vocational, and financial factors, and evaluate their relevance and applicability to women across diverse contexts.

Evaluating wellness models against the three foundational dimensions—physical, social, and emotional/mental—reveals notable strengths and gaps. The Eight Dimensions of Wellness Model stands out for its comprehensive coverage of these foundational dimensions and additional areas like financial and vocational wellness. However, it lacks attention to women-specific needs, such as caregiving and reproductive health, and has not been culturally adapted. Similarly, the Wellness Consensus Model incorporates mental health, social networks, and physical activity while addressing broader domains like work-life balance and lifestyle habits. It remains conceptual and unvalidated in diverse cultural or gender-specific contexts. Models like the Wheel of Wellness and the Indivisible Self Model partially cover the foundational dimensions. The Wheel of Wellness emphasizes social and psychological wellness, particularly spirituality. Still, it lacks focus on physical health, while the Indivisible Self Model is integrated and highly relevant to psychological well-being but needs expansion to address physical health and systemic women-specific issues. On the other hand, models like the Illness-Wellness Continuum and High-Level Wellness fail to comprehensively address all three foundational dimensions, focusing more narrowly on the spectrum of health or self-actualization, often neglecting critical social and emotional components. These findings underscore the need for a more inclusive and culturally adapted framework that holistically addresses women's wellness.

Regarding the intended demographic, specific models, exemplified by NWI's Six Dimensions, are constructed to possess broad applicability across various populations. Conversely, other frameworks, such as the Whole-Person Wellness Model, concentrate more specifically on distinct groups, including working professionals. This delineation suggests that several models may necessitate adaptation to enhance the inclusivity and representativeness of heterogeneous populations. Lastly, gender-specific applicability has emerged as a crucial consideration since 1992.[14] A limited number of the models directly tackle the distinctive wellness requirements of women. Most models fail to incorporate dimensions or challenges pertinent to women, including reproductive health, caregiving duties, or the balance between work and personal life, all of which are vital for a comprehensive understanding of women's wellness.

Among the models reviewed, the Eight Dimensions of Wellness Model and Wellness Consensus Model stand out as the most comprehensive frameworks addressing women's wellness. The Eight Dimensions of Wellness Model stands out as a comprehensive, validated framework encompassing emotional, social, financial, spiritual, occupational, physical, intellectual, and environmental wellness. However, despite its breadth, this model does not explicitly address factors within these dimensions that are unique to women's needs, such as reproductive health and caregiving responsibilities. Also, gender disparities are particularly evident in occupational wellness, as women often face unequal pay and the burden of unpaid caregiving responsibilities. If this model were tested and validated within different contexts or among women specifically, additional dimensions or factors might emerge to reflect their unique experiences and challenges better.

This study primarily aimed at pre-existing wellness frameworks that lack detailed primary data collected from non-Western populations, which may hinder the broader applicability of the conclusions drawn. Subsequent inquiries ought to integrate direct input from women inhabiting varied cultural environments to enhance the precision of wellness frameworks. Future investigations should prioritize formulating culturally nuanced wellness models that integrate gender-specific elements, especially within non-Western societies, to elevate the comprehension of holistic wellness for women on a global scale. In summary, this discussion underscores the necessity for a more inclusive and culturally pertinent

approach to wellness models, particularly for women in non-Western environments. By modifying these frameworks, we can more effectively cater to the distinct wellness requirements of women worldwide.

The Gap in the Literature

There exist numerous significant areas for improvement in current wellness frameworks that constrain their applicability and overall comprehensiveness. A primary deficiency pertains to cultural specificity, as many models are formulated within Western paradigms and need to consider the wellness requirements of individuals from varied cultural backgrounds. This deficiency in cultural awareness diminishes the global applicability of these frameworks. Furthermore, there is a conspicuous absence of emphasis on gender relevance. A limited number of models explicitly engage with the distinctive wellness requirements of women, particularly in non-Western contexts, where societal roles and expectations can profoundly influence well-being. Another critical deficiency is the matter of validation. Specific wellness models have not undergone rigorous empirical validation, which undermines their practical applicability in real-world environments and obstructs their integration into both research endeavors and practical applications.

In summary, each theoretical model embodies the cultural, social, and health-related imperatives characteristic of the region from which it originates. Additionally, the applicability of these models to diverse populations may vary depending on whether they were explicitly designed for specific demographics or have undergone adaptations for broader utilization. It is also imperative to comprehend how these models either address or overlook gender-specific concerns, particularly in the context of evaluating their applicability to women's health and wellness.

Disclosure

The authors report no conflicts of interest in this work.

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