Horizon J. Hum. Soc. Sci. Res. 4 (1): 25 – 36 (2022)

Journal of Humanities and Social Sciences Research
www.horizon-JHSSR.com

CONCEPTUAL
Peer-reviewed | Open Access

Meeting the Need of Help-seekers with an Empowerment Model: A Shift in Emotional Wellness

Rosenna Bakari, PhD

Department of Counseling and Human Services, College of Education, University of Colorado, Colorado Springs, 1420 Austin Bluffs Pkwy, Colorado Springs, CO 80918, U.S.A.

ARTICLE INFO

Article history
Received: 15-Mar-22
Revised: 4-May-22
Accepted: 20-May-22
Published: 15-Jun-22

*Corresponding Author
Rosenna Bakari
E-mail: Rbakari2@uccs.edu

Citation: Rosenna Bakari (2022). Meeting the Need of Help-seekers with an Empowerment Model: A Shift in Emotional Wellness. Horizon J. Hum. Soc. Sci. Res. 4 (1), 25–36. https://doi.org/10.37534/bp.jhssr.2022.v4.n1.id1148.p25.

ABSTRACT

Only time will tell the long-term outcomes of the pandemic on mental health based on the increase in treatment for substance addiction, depression, anxiety, and chronic mental illness flare-ups. However, the shift in how helping professionals respond to help-seekers was one significant outcome. The volume of tele-mental health services was unprecedented during the pandemic. Unfortunately, many clinicians were not trained to provide online support and suffered burnout from the demand. There is no doubt that the field of mental wellness is subjected to the dictates of virtual demands like the rest of the world. In such a case, the permanence of the online delivery response to help-seeking should be supported by online models of delivery. This article outlines an approach to mental wellness using an empowerment model developed by the author. The Empowerment Model of Emotional Wellness was designed as an online delivery product prior to the high demand for online service. It is not a response to COVID quarantines. Instead, it is a response to the need to remove help-seeking obstacles. The Empowerment Model of Emotional Wellness offers a prescribed curriculum to increase the efficacy of the practitioner and maximize the therapeutic value for the client. Its aim is to neutralize the negative power dynamics between client and practitioner, and reorient clients to their inner world using experiential processes.

Keywords: Help-seeking, Mental Health Counseling, Trauma-informed, Cognitive Psychology, Emotional Wellness Support

Introduction

The increased complexity of living taxes the mind and forces it to work harder. The hardworking mind shifts attention away from its internal balance to keep up with external demands and increasingly needs help to re-center (Fromm, 2021; Mental Health America, 2020; O'Connor, et al., 2021). COVID-19 quarantines threatened everyone's emotional wellness while protecting their physical health (Holingue, et al., 2020). Only time will tell the long-term outcomes of the pandemic on mental health based on the increase in treatment for substance addiction, depression, anxiety, and chronic mental illness flare-ups (Lowe, Keown-Gerrand, Ng, Gilbert, & Ross, 2022; Venkatesh, et al., 2022). However, the shift in how helping professionals respond to help-seekers was one significant outcome (Adams, et al., 2018). The volume of tele-mental health services was unprecedented during the pandemic (Lo, et al., 2022). Unfortunately, many clinicians were not trained to provide online support and suffered burnout from the demand. According to a study of 768 United States therapists, the use of telepsychology increased from 39% pre-COVID-19 to 98% during quarantine (Sampaio, et al. 2021). Most of the study participants reported that they received no pre-professional training on telepsychology. Research by Zhu, et al. (2021) suggests that mental health professionals have become more efficacious from their forced online service delivery. Their study indicates that most practitioners plan to permanently offer it.

The field of mental wellness is subjected to the dictates of virtual demands like the rest of the world (Sampaio, et al. 2021; Wolfers & Utz, 2022). According to Mahapatra (2020), "the desirable solution going forward is the existence and adaptation of a world which is a perfect amalgamation of both physical and virtual spaces." In such a case, the permanence of the online delivery response to help-seeking should be supported by online models of delivery. This article outlines an approach to mental wellness using an empowerment model developed by the author. The Empowerment Model of Emotional Wellness was designed as an online delivery product prior to the high demand for online service. It is not a response to COVID quarantines. Instead, it is a response to the need to remove help-seeking obstacles. For example, Burkett (2017) calls for "mental health providers to implement more nonbiased, multifaceted, contextually based treatments or interventions" to effectively serve Black Americans. The Empowerment Model of Emotional Wellness offers a prescribed curriculum to increase the efficacy of the practitioner and maximize the therapeutic value for the client. The wholistic approach is developed to:

1. remove obstacles to help-seeking,
2. neutralize the negative power dynamics between client and practitioner, and
3. reorient clients to their inner world using experiential processes

Today's complex world warrants a sophisticated approach to meet the needs of help-seekers (Amen, Milton H. Erickson Foundation, & Alexander Street (Firm), 2020; Burkett, 2017). The use of a curriculum that aligns with research driven psychological constructs offers several potential benefits to the mental health profession, including decreased counselor burnout, higher client completion, and reduced resistance in the therapeutic relationship (Brett, et al. 2020; Lloyd, 2020). Counselors play an active role in guiding the experiential process by using the set curriculum to expedite getting to the core of the client's disempowerment. The preset number of sessions makes it easier for clients to commit to completion, while replacing the traditional invasive evaluation process with empowerment choices reduces the client's resistance (Hymmen, Stalker, & Cait, 2013; Reynolds, et al., 2022).

Theoretical Framework

Empowerment increases the individual's capacity to make and transform choices into desired actions and outcomes (Baba, et al. 2017; Hossain, Asadullah, & Kambhampati, 2019). The Empowerment Model of Emotional Wellness is an approach to restore an individual's internal expression of power. Empowerment enhances a client's ability to regulate emotions, delay gratification, and predict outcomes based on effort. Empowered people master themselves with a healthy balance of internal and external fulfillment and mental flexibility. They thrive, even in unfamiliar territory. They minimize conflict without shrinking themselves to please others. They impose their will on the world without harming others, live with a strong sense of independence, and self-soothes. They make decisions based on present conditions, rather than fears from their past (Grealish, et al., 2017; Miguel, Ornelas, & Maroco, 2015).

Empowered people commit to living their best lives, and can experience various emotions simultaneously. Unplanned changes can cause mental exhaustion and elicit joy simultaneously, such as a promotion that requires relocation or an unexpected pregnancy. Empowerment is internal fortitude that centers around self-discipline and balance. It takes internal confidence to follow as well as lead, help instead of criticizing, study instead of giving up, or change instead of complaining. The discipline of the mind, body, and spirit is the ethos of empowerment. It requires self-exploration to examine the ideologies, wounding experiences, and debilitating beliefs that elicit patterned defensive reactions. Empowered people uphold empowerment attributes more often than not.

People who are disempowered have difficulty in one or more of the following areas: mental flexibility, orienting toward the present, cognitive predictability, emotional independence, and truthful living. A disempowered mind has little flexibility. It doesn't move with ease because it is heavy. An added feather will send the disempowered, heavy mind crumbling, metaphorically speaking. The smallest request seems monumental (Fromm, 2021; Perry & Winfrey, 2021; Van der Kolk, 2014). Help-seekers do not state the absence of empowerment traits when they seek help. The presenting problem often has something to do with someone else (Satir, 1991).

Contemporary experts and authors on emotional wellness have shown that a state of powerlessness can compromise brain functioning. Bessel Van der Kolk, a preeminent neuroscientist, documented the relationship between trauma and the brain in his book, *The Body Keeps the Score* (Van der Kolk, 2014). Van der Kolk (2014) offers a series of case examples to challenge the over-use of prescribed medication to treat trauma. He asserts that deep understanding and acceptance can create space for many clients to heal along with breathing, moving,

and touching. Dr. Bruce Perry, a prominent psychiatrist, espoused the same conclusions in his co-authored book with Oprah Winfrey, "What Happened to You?" (Perry & Winfrey, 2021). The Empowerment Model of Emotional Wellness reflects the understanding that talking and cognitive processes alone are insufficient to rewire the brain that has been disempowered (Christens, Collura, & Tahir, 2013; Hsiung, 2000; Hymmen, Stalker, & Cait, 2013).

False perceptions about one's power based on personal or vicarious experiences result from many circumstances, including:

- Outdated information from childhood where powerlessness was instilled
- Reliance on someone carelessly wielding power
- Traumatic consequences from the use of personal power

For more than half a century, psychologists have concluded that the quality of caregiving in childhood is a significant predictor of adult function. Freud, reputed as the father of psychoanalysis, related psychosis to the absence of care. Accordingly, adults often live as emotional children fixated on fulfilling unmet childhood needs (Lear, 2015/2014). Freud, asserted that a person "who has not appropriately transmuted his sexual energy which is essential for achievements later in life, will always find it difficult to derive happiness from the external environment, and remarkably more if he faces difficult tasks" (Freud, 1930, p.22).

Some psychologists found Freud's sex-centered ideas too provocative and developed alternative theories that shared Freud's fundamental premise about unmet childhood needs, including Carl Jung. Jung and Freud worked together on building an understanding of the human mind. However, Jung rejected sex as a driving force of development and focused more on lived experiences as the negotiation of emotions (Jung, 2013). Alfred Adler, an Austrian psychologist, reputed as the founder of individual psychology, also highlighted childhood as significant to adult functioning. He claimed that "*the fundamental factors which influence the soul life are fixed at the time when the child is still an infant"* (Adler, 2013, p.23).

Abraham Maslow, influenced by existential philosophers, *structured human development into a stage-theory of motivation. He considered the basic needs such as belonging, and self-esteem as requirements for finding deeper meaning in life. "By definition, self-actualizing people are gratified in all their basic needs" (Maslow, 1967). Erikson agreed with Freud's theory of an ego identity influenced by the environment, but proposed the identity to be psychosocial rather than psychosexual.*

> *It is important, however, that we all agree that the need for identity has emerged with the evolution of man as an animal with an intricate interdependence of individual development and social organization; and that it evolves with each man's ego – development as a psychosocial necessity crowning all of childhood* (Erikson, 1962, p.432).

While psychologists agreed, evidence on the relationships between adult functioning and childhood experiences was tenuous using traditional research methods (Narvaez, 2018). Isolating caregiving variables is impossible with humans. So, theories were developed based largely on assumptions based on observations (Adler, 2013; Erikson, 1962; Freud, 1930; Jung, 2013). That is, until research on adverse childhood experiences broke through the ceiling with correlation research (Felitti, et al., 1998).

The Adverse Childhood Experiences (ACEs) research moved psychology theories beyond assumptions (Felitti et al., 1998). The Center for Disease Control and Kaiser Permanente Healthcare conducted one of the most extensive studies on adverse childhood experiences to determine a cumulative effect (Centers for Disease Control and Prevention, 2021). The study measured the health status of adults who experienced from zero to ten adverse childhood experiences. The ACEs survey identified ten items related to physical, sexual, neglect, emotional abuse, violence perpetrated on the mother, incarcerated family member, drug abuse, and divorce. This correlation study showed a strong relationship between adverse experiences and vital health outcomes such as high blood pressure, COPD, and alcoholism. The more ACEs adults experienced, the more chronic illness they reported (Centers for Disease Control and Prevention, 2021). While the research is not causal but correlational, it is the most robust empirical evidence that childhood experiences matter. Like the Freudian-based theories and the ACEs research, the Empowerment Model of Emotional Wellness recognizes the critical contribution childhood experiences make to adult wellness. The curriculum invites clients to explore the connection between past and present life experiences as they relate to empowerment and wellbeing.

High-quality childhood experience, though it is a protective factor, does not immunize adults to the cruelty of the world. The would-be dream job can turn into a nightmare by a micro-managing boss with unreasonable demands. Even a reasonably adjusted adult may fear setting boundaries with an authority figure. Similarly, a woman whose

parents love and care for her may have traditional ideas about men being providers and women subservient. However, commitment to an overbearing husband may create emotional distress. The demanding boss and domineering husband are examples of careless or abusive use of power. Reliance on these types of people may disempower an adult. The adult must let go of their idea about career, love, or marriage to restore personal power (Fromm, 2021).

People can also experience unwanted consequences from their use of power. Maya Angelou told the story about how she became selectively mute for five years because she held herself responsible for the death of the man who raped her after he was murdered in jail (Angelou, 1979). Many victims mute their power to save someone from harsh consequences. They would rather be powerless than responsible for harming a person. Silence is a temporary solution. The Empowerment Model of Emotional Wellness supports clients in using their voice and living in the power of truth.

Empowerment work is less attractive for practitioners who insist that change must be measured. The Empowerment Model of Emotional Wellness may not lend itself to statistical measures because the expected outcomes are not standardized (Christens, Collura, & Tahir, 2013). Numerous positive effects related to empowerment do not lend themselves to objective measures (Jung, 2013). To ask the thinking mind to report on the feeling mind is a validity error in measuring the shift in focus from external to internal, self-soothing practice, releasing shame, an increased will to live, or releasing fear as a decision-maker. Measuring the effect of empowerment work on the individual would be impossible. One client may sleep better while another client gets a promotion at work because of feeling more empowered. The result is wholistic. It does not seek to solve a single problem. Instead, it aims to empower clients to meet every would-be problem from a place of empowerment (Cheung, Mok, & Cheung, 2005). Clients fine-tune their internal antennas by becoming the watcher of their thoughts, feelings, and actions instead of being consumed by them. The work teaches clients to become less a victim of the mind (Baba, et al. 2017). They watch the patterns of their minds without judgment and learn to trust themselves. This inner focus is the exchange from their previous external focus that rendered them powerless as a response to past distress.

Counselors must be trained to attune themselves to clients' immediate needs (Satir, 1991). For example, the client who talks fast and nonstop may benefit from five minutes of meditation before or during a session. Visualization may be the best tool for a client who ruminates. Reading a book together could reinforce a critical concept. Practitioners must remain clear-minded to track the client and utilize the appropriate tool at the right time. The work between the client and practitioner is highly engaging. The curriculum does not structure the session; it only anchors it. The practitioner must attend each session prepared to work, not just listen.

Focus on Empowerment

The Empowerment Model for Emotional Wellness does not treat clients for depression, anxiety, grief, or anything else. Practitioners help clients navigate inner safety, competence, and confidence. Self-awareness develops mental flexibility, and as clients come to know and honor themselves deeply, they develop healthier patterns to create optimal lives (Tekleab, et al., 2008; Venkatesh, et al., 2022). Clients are guided to set and respect healthy boundaries, self-soothe, and make good decisions based on what they want rather than what they fear. Self-mastery enables clients to govern their lives in a way that brings them joy (Lloyd, 2020).

Removing Help-seeking Obstacles

The Empowerment Model for Emotional Wellness eliminates invasive evaluations and diagnoses that may prevent people from seeking traditional counseling (Burkett, 2017; Butler, Critelli, & Rinfrette, 2011). Traditional intake evaluations are designed to find clients' flaws, problems, or dangers before practitioners establish a relationship with clients (Shea, 2017). Clients often begin therapy with resistance to disclosure and the hierarchical client-helper relationship (Windle, et al., 2020; Wolfers & Utz, 2022). The consequence is a hefty dropout rate. Saxon, Rickettts, & Heywood (2010) reported a 34.4% dropout rate in their study of 1224 counseling clients. Empowerment Model of Emotional Wellness practitioners establish a partnership with clients by replacing evaluations with consultations. The initial consultation explores what clients would like to address without demanding deeply personal information in exchange. Clients often want to know more about the practitioner before disclosing anything. Empowerment partners respond to clients' uncertainty before requiring vulnerability.

Even when traditional therapeutic approaches are structured to keep clients' thoughts in the present, evaluations focus on clients' history - an unnecessary contradiction

(Shea, 2017). The client's educational attainment, marital status, hospitalizations, adverse childhood experiences, and use of substances are asked matter-of-factly and without regard to the client's comfort. The practitioner has no idea which information is pertinent to the client's situation, and this standardized approach to help-seeking disempowers clients (Gelkopf, Mazor, & Roe, 2021). Practitioners empower help-seekers with information instead of questions. Help-seekers enter a relationship with the empowerment partner with dignity and as their own authority. When possible, help should be available without stigma, an attached diagnosis, or subjugation (de Hann, et al., 2015; Hymmen, Stalker, & Cait, 2013). The model aims to replace barriers to the therapeutic process with client empowerment.

The Curriculum

The empowerment relationship between practitioners and help-seekers supports risk-taking and vulnerability, which are essential for growth and transformation (Okon & Webb, 2014; Sartorius, 2011). Partners and clients work together with shared power that centers around the curriculum. Help-seekers do the work sooner when it is explicit (Brett, et al. 2020; Lloyd, 2020). The eight explicit wellness modules of the Empowerment Model of Emotional Wellness curriculum are emotional defenses, attachment, cognitive dissonance, building relationships, self-care, life principles, identity, and success. Clients may work through these modules in as little as eight weeks or as many as eight months.

Empowerment practitioners design a flexible plan based on the consultation. It states how often the client and practitioner will meet and what they plan to accomplish in each session, as transparency is essential. Sessions are experiential, not limited to talking and listening. Homework is assigned session by session to meet a specific need. The homework requires clients to absorb some information by video or reading and complete an assignment for self-awareness.

Homework assignments anchor the sessions. Clients engage in experiential work such as completing observational worksheets about their patterns, listening to meditations, reviewing their past through photos, writing poetry, listening to audiobooks, or trying out new behaviors. The practitioner is responsible for making meaning of the assignments and using them to probe further into the client's cognitions and emotions. Experiential work allows the process to be messy and unpredictable despite the curriculum structure (Pascual-Leone, 2009). Clients move beyond thinking and talking and into the experience of creativity and exploration of parts of self. Practitioners help clients put together enough pieces of their history to understand their current patterns and work to accept what they come to understand. Then they explore new ways of being in the world. Clients do not know how far back in their history the work will take them, but their history exploration occurs within a context of wellness rather than victimization. The practitioner does not ask the client for stories about their past (Foundation, 2020). They probe for connections to concepts of wellness.

Practitioners must not judge the completion of homework as a commitment to wellness. There are reasons a client may not complete an assignment, such as the fear of being triggered or a lack of time. If left undone, practitioners can strategically cover most homework in the session. Each session has components that teach about wellness and support personal insights, but the curriculum is the tool, not the goal. General descriptions and sample homework assignments describe how session objectives may be met.

Session one: Emotional defenses

Clients explore their use of emotional defenses in everyday life. They learn how the brain creates patterns of

Table 1: Summary of Empowerment Model of Emotional Wellness Curriculum Objectives and sample homework

Session	Purpose	Prep Activity
1	Explore client's emotional defenses.	Client tracks their use of emotional defenses.
2	Explore client's early influences.	Utilize childhood images to assess emotional development.
3	Support clients in seeing themselves as a free agent in the world.	Clients create something.
4	Reflect on relationship approach based on client's past experiences.	Complete expectation for behavior questionnaire.
5	Lean into the vulnerability of trial and error.	Client assess how their time is spent.
6	Replace outdated scripts of conformity to align with adult responsibility.	Client writes ten guiding life principals.
7	Conscious awareness of client's identity deepens commitment to self-definition.	Client writes an "I am" identity Poem.
8	Determine next steps	Review progress

responses to subdue emotional stress. Understanding that their brain rationales do not represent their authentic self is the first invitation to release self-judgment. As clients learn their brain patterns, they know that change is possible. Everyone uses defense mechanisms to make life a little easier. This understanding allows clients to look at themselves with empathy and honesty as they move through the remaining lessons. Practitioners get their first at clients' willingness to be vulnerable with others and honest with themselves.

Homework requires clients to note how they use the defenses they learned about during the week. For each defense, they make notes about when they used it, why they used it, and whether the defense resulted in a desirable outcome. Seeing the available defenses versus their selected defenses allows them to see that they are making choices without the practitioner telling them. The focus is not on their external environment but rather their internal response.

Session Two: Emotional attachment

People are unaware that they live by scripts passed down to them by their caregivers. They believe that the way they view the world is common sense or unbreakable universe rules. Session two unveils outdated scripts for clients' current lives. Clients begin exploring the early influences on how they see the world. They begin to see how they are held hostage emotionally by restricting themselves to a hand-me-down life.

The homework assignment requires the client to find photos of themselves at different developmental ages. Based on each picture, the client indicates their experience with emotions on a scale of one to ten. They complete the same scale based on their recent experience with the emotions. Practitioners help make meaning of the differences in scores for clients. This session indicates whether inner child work should be approached within the remaining sessions.

Session Three: Self-Regulation

Session three blends the first two sessions as clients explore the complexity of change based on how the brain works. Clients move into a deeper appreciation for how they have utilized emotional defenses. The brain recognizes patterns and marks them as significant for survival, not right or wrong. The patterns that have been around the longest are the most familiar, thus, preferred by the brain. Most of the patterns clients live with represent childhood notions about themselves and the world. This session may explore the inner child persona and begin the process of re-parenting.

For homework, clients create something – anything. This activity allows clients to see themselves as free agents in the world. They can make rules instead of following them, create boundaries instead of obeying them, and be seen rather than shrink. The task shines a light on clients' readiness to lead their own lives. Even clients in leadership positions have difficulty transferring their power to direct their own lives creatively.

Session Four: Relationships

Relationship narratives contribute significantly to life satisfaction and reflect how people see themselves. Relationship dissatisfaction may be the only sign of internal dysfunction for people with high resiliency. When emotional wounds linger, healthy relationships are challenging to maintain. Clients reflect on their relationship approach based on their past experiences, particularly adverse childhood experiences. In session four, practitioners review the first three lessons to help clients see the narrative they are living by in their relationships.

For homework, clients quantitatively assess how they treat themselves compared to their expectations of how others should treat them. The activity requires clients to complete a ranking scale of expectations that explicitly shows whether a client's expectations of others outweigh their self-care. The practitioner aids in reorienting the client's commitment to taking care of their emotional needs rather than expecting others to do so.

Session Five: Self-care

The last four modules aim to help clients reconstruct their sense of power, whereas the first four modules identify how they lose it. Module five reinforces clients' responsibility to make decisions that support wholistic wellbeing. For every raised concern, the client is challenged to shift something about their lives to make a difference. By now, they know enough about themselves, their environment, and the world to take responsibility for creating the life they desire. They lean into the vulnerability of trial-and-error practice.

The homework requires clients to assess how they spend their time and the outcomes of their daily and weekly

activities. The practitioner aids clients in exploring ways to achieve the balance they want while supporting new behaviors. This process requires revisiting whatever was uncovered in the first four modules. Practitioners encourage clients to "do," not just talk and assess. Practitioners reflect for clients where they hear inconsistencies in clients' commitment to wellness and their behaviors.

Session Six: Guiding life principles

Practitioners support clients as they learn to hold themselves morally and emotionally accountable. Having come to understand the connection between their past and present, clients imagine a self-designed life. They have questioned their default choices and created new life scripts. Clients may become less at ease as they live with the trial and error consequences of their decisions.

Clients complete an assignment to write their ten guiding life principles. These guiding principles replace outdated scripts of conformity. The practitioner affirms clients' will to align with adult responsibility rather than default decision-making based on fear. Practitioners help clients focus on their life based on their guiding principles and accept the outcomes.

Session Seven: Identity

Session seven focuses on identity work, which is central to empowerment. Identities give or inhibit power and privilege, depending on how clients use them. Sometimes identities are presented within this work, and sometimes the work removes them or changes the narrative. For example, accepting the survivor of childhood abuse identity could make a client feel less alone. On the other hand, growing away from victim-identity as a survivor could release codependency. Recreating the narrative of being a survivor can help a client shift perspectives. Identity work may include roles such as a parent, experiences like being a survivor, or bio-social such as race and gender. The identity module deepens clients' commitment to self-definition.

Homework requires clients to write an identity poem. This activity invites clients to look at who they thought they were at the beginning of the work and who they imagine themselves to be at the end. They may not feel empowered yet, but they embrace the journey to empowerment with the practitioner's support. Practitioners affirm while simultaneously challenging clients where there are inconsistencies.

Session Eight: Success

Clients define success on their terms in session eight. Clients review the previous sessions and growth outcomes with the practitioner to determine the next steps in their healing journey. They have acquired enough knowledge about themselves to know how to use their vulnerability and strength. The completion of the program is the beginning of their conscious empowerment path.

Session eight is the only session where the client and practitioner discuss what happens next. They should not determine the next steps in their relationship any sooner. There are several options for the next steps; none involve a curriculum. The curriculum raised self-awareness and increased personal responsibility to the client. Clients know their obstacles to wellbeing and have a good idea of the depth of work that remains. They can continue the work with the practitioner formally or continue to do it independently with the practitioner as a resource.

Future work with the practitioner is determined by the tools in the practitioner's toolbox and the client's preference for support. Additional sessions should be clearly defined in purpose and limited in number. Clients should know what they are working toward and how they are working toward it. The number of sessions should never exceed eight. The practitioner is responsible for performing their way out of a job with each client.

Benefits toward Mental Wellness

A relationship between life satisfaction and empowerment has been found (Cheung, Mok, & Cheung, 2005; Hossain, Asadullah, & Kambhampati, 2019; Roos, et al., 2016). The curriculum provides transparency and accountability between the client and practitioner. Clients' active participation in customizing the curriculum begins the empowerment process. Homework keeps clients engaged in the work and ready to attend each session (Foundation, 2020; Harwood, L'Abate, & SpringerLink (Online Service), 2010;2009). The curriculum does not require clients to tell a story about their lives or other people. It takes the client out of a storytelling context where they are more resistant to change because their behavior always makes sense. The curriculum places clients' emotions and behaviors within a personal wellness context to see how their patterns benefit them, not just make sense (Felitti et al., 1998; Jost, 2020).

Clients do not have to figure out what to discuss, and they always know where they are in the curriculum of change. Although clients address past events when the context requires it, they do not focus on what was done to them. Instead, they focus on their lingering responses (Lloyd, 2020). The practitioner helps the client see connections between their responses from the past and their current responses that impede their wellbeing. The practitioner reassures clients that every action makes sense when the context supports it. The problem is that embedded responses do not change even when the context has changed (Lim, et al., 2019; Peterson, Grippo, & Tantleff-Dunn, 2008; Lim, et al., 2019; Rucker & Galinsky, 2008). The wellness curriculum presents a safe context to change their patterned behaviors to support wellness.

Delivery of Service

Sessions may last from one to two hours to support a client-ready ending. Clients have sufficient time to ask questions about the curriculum and process their experiences. Online delivery has several advantages (Hsiung, 2000; Leonard, Quesenberry, & Lindsay, 2015; Notredame, et al., 2018). Significant advantages are:

- Real-life observations
- Empowered environment
- Convenience
- Safety
- Costs effectiveness

Clients' homes offer real-life observations to practitioners (Dosani, Harding, & Wilson, 2014). Practitioners decide what to do with the observational data, but their decision must empower and not shame the client. How clients show up varies considerably compared to an office visit. A client may show up with a glass of wine, smoking marijuana, or in pajamas, which speaks volumes to their anxiety despite their calm tone. Clients' room for sessions also may say something about their ease of decompressing. If there is no space in the home to have a private conversation, the lack of privacy may be pertinent to their ability to practice new behaviors. Where ever clients hold the session, their choice matters. When clients must travel to an office, their power may already be reduced.

Clients will choose the most comfortable space available to them. When they do, they position themselves for vulnerability. Inviting them to explore what is uncomfortable is easier when they are in a natural or personal environment. Clients can be more expressive in their anger without the partner feeling threatened. Moreover, the lack of travel means missed appointments are infrequent. For convenience, if clients cannot make it home, they can complete the session at work or even in their car. A personal environment lends itself to risk-taking in session. Clients can utilize their sofa for visualizations. They can retrieve personal items on demand, such as showing a picture. They may even introduce a family member. These opportunities are absent in office settings. The familiarity of the environment enhances rather than stifles the quality of the connection between the client and practitioner (Deandre, 2015; Dosani, Harding, & Wilson, 2014; Hsiung, 2000).

The practitioner and client agree on a personalized curriculum layout and sign a contract after the consultation. The client completes homework - required activities and videos or articles on the topic before each session. The practitioner fills in any information gaps and guides clients into exploring empowerment based on their response to the homework. The Empowerment Model of Emotional Wellness places clients at the center of their lives to make decisions, act on desires, and lean into vulnerability to design an empowered life. Sometimes clients' lives become disrupted, or relationships end as part of the process, and clients' pain is elevated before they feel better. Letting go of what no longer serves them often hurts. So, helping clients maintain motivation to do the work is an essential aspect of the practitioner's role. Safety and overhead costs are beneficial to the practitioner.

Conclusion

The Empowerment Model offers significant advantages to help-seekers and practitioners as it removes obstacles to help-seeking. It uses a collection of cognitive, emotive, and experiential tools to restore power, including visualization, exercise, experiential behaviors, role play, reading assignments, and meditation in sessions and as homework to restore power. The goal is to work with clients to access their power by turning their attention inward. When clients see where they have lost power, given it away, or never developed it, they want to restore it. People with mental health conditions are entitled to the least restrictive environment (Crockett & Kauffman, 1999). However, many clients are unwillingly subjected to a psychological diagnosis to talk with a professional. A diagnosis is restrictive, as is the requirement to meet in an office for narrowly-timed sessions. Many help-seekers opt out of these restrictions even if they must pay in full and bypass insurance companies (Schilling, et al., 2022). The wholistic approach changes lives by focusing on empowerment, not just problems.

Practitioners are not guided by insurance companies but do what is best for clients (Adams, et al., 2018). To the degree that insurance bridges the financial gap between clients and practitioners, the author recognizes the potential disadvantage of working without a diagnosis, as a diagnosis is required for insurance payment. However, limited sessions could be less costly than a co-payment over time. There is little incentive to terminate clients if practitioners treat problems or diagnoses because problems will always exist. Many clients self-terminate without closure when insurance runs out. The Empowerment Model of Emotional Wellness may lower the risk of attrition by clients' agreement to a set number of sessions. Moreover, many clients desire to control their own psychological intervention.

Client agreement is essential to the entire experience of empowerment. Practitioners guide and assist, but not demand. When practitioners remove themselves as authority figures and return power to the client, they also have the authority to take risks. Practitioners foster clients' tolerance for the trial and error required to develop new behaviors. Empowerment practitioners partner with clients to restore their power using a curriculum and self-reflection activities. There is no one-size-fits-all to meet the needs of help-seekers. This approach may be optimal for clients who are resistant to diagnosis, ready to take responsibility for designing an empowered life, and are willing to complete a curriculum for wholistic mental wellness instead of problem-solving. It invites clients closer to themselves to shut out the noise of the external world.

Competing Interest

This author declares that there is no known competing interest in the submission of this article.

Acknowledgements

The author acknowledges each client who trust me with their pain. I appreciate the opportunity to practice what I believe so that I can write about this process with confidence. My colleagues who help me wrestle with new concepts also give me the courage and motivation to share my insights. I write with much gratitude.

References

Adams, S., Rice, M., Jones, S., Herzog, E., Mackenzie, L., & Oleck, L. (2018). TeleMental health: Standards, reimbursement, and interstate practice. *Journal of the American Psychiatric Nurses Association, 24*(4), 295–305. https://doi.org/10.1177/1078390318763963.

Adler, A. (2013). *Understanding Human Nature.* Routledge.

Amen, D. G., Milton H. Erickson Foundation, & Alexander Street (Firm). (2020). The end of mental illness. *The evolution of psychotherapy.* Milton H. Erickson Foundation.

Angelou, M. (1979). *I Know Why the Cage Bird Sings.* New York, New York: Random House.

Baba, C., Kearns, A., McIntosh, E., Tannahill, C., & Lewsey, J. (2017). Is empowerment a route to improving mental health and wellbeing in an urban regeneration (UR) context? *Urban Studies, 54*(7), 1619–1637. https://doi.org/10.1177/0042098016632435.

Brett, C., Wang, K., Lowe, S., & White, M. (2020). Evaluation and Durability of a Curriculum-Based Intervention for Promoting Mental Health among Graduate Students. *American Journal of Health Education, 51*(6), 350–359. https://doi.org/10.1080/19325037.2020.1822240.

Burkett, C. (2017). Obstructed use: Reconceptualizing the mental health (help-seeking) experiences of Black Americans. *Journal of Black Psychology, 43*(8), 813–835. doi:10.1177/0095798417691381.

Butler, L., Critelli, F., & Rinfrette, E. (2011). Trauma-Informed Care and Mental Health. *Directions in Psychiatry*, 197-210.

Centers for Disease Control and Prevention. (2021, April). *Adverse Child Experiences (ACEs)*. Retrieved February 10, 2022, from CDC: Violence Prevention: https://www.cdc.gov/violenceprevention/aces/index.html

Cheung, Y. W., Mok, B.-H., & Cheung, T.-S. (2005). Personal empowerment and life satisfaction among self-help Group members in Hong Kong. *Small Group Research, 36*(3), 354–377 https://doi.org/10.1177/1046496404272510.

Christens, B. D., Collura, J. J., & Tahir, F. (2013). Critical hopefulness: A Person centered analhysis of the intersection of cognitie and emotional empowerment. *American Journal of Community Psychology, 52*(1-2), 170–184 https://doi.org/10.1007/s10464-013-9586-2.

Crockett, J., & Kauffman, J. (1999). *The Least Restrictive Environment: Its origins and interpretations in special education.* Mahwau, NJ: Routledge.

de Hann, M., Boon, A. E., de Jong, Joop, T., & Vermeiren, R. (2015). A review of mental health treatment dropout by ethnic minority youth. *Transcultural Psychiatry, 55*(1), 3–30. https://doi.org/10.1177/1363461517731702.

Deandre, D. (2015). Testing the proclaimed affordances of online support groups in a nationally representative sample of adults seeking mental health assistance. *Journal of Health Communication, 20*(2), 147–156. https://doi.org/10.1080/10810730.2014.914606.

Dosani, S., Harding, C., & Wilson, S. (2014). Online groups and patient forums. *Current Psychiatry Representations, 16*(11), 501–507. https://doi.org/10.1007/s11920-014-0507-3.

Erikson, E. (1962). Reality and actuality an address. *Journal of the American Psychoanalytic Association, 10*(3), 451–474. https://doi.org/10.1177/000306516201000301.

Felitti, V.J.; Anda, R.F.; Nordenberg, D.; Williamson, D.F.; Spitz, A.M.; Edwards, V.; Koss , M.P.; Marks, J.S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: the adverse childhood experiences (ACE) study external icon. *American Journal of Prevention Medicine, 14*, 245–258.

Foundation, M. H. (Producer). (2020). *Feeling great: A New High-Speed Treatment for Depression* [Motion Picture].

Freud, S. (1930). *Civilization and It's Discontent.* Hogarth.

Fromm, E. (2021). *The Fear of Freedom* (New ed.). Routledge.

Gelkopf, M., Mazor, Y., & Roe, D. (2021, April 1). A systematic review of patient-reported outcome measurement (PROM) and provider assessment in mental health: goals, implementation, Setting, Measurement characteristics and arriers. *International Journal for Quality in Health Care, 34*(Suppl 1), ii13–ii27. https://doi.org/10.1093/intqhc/mzz133.

Grealish, A., Tai, S., Hunter, A., Emsley, R., Murrells, T., & Morrison, A. (2017). Does empowerment mediate the effects of psychological factors on mental health, well-being, and recovery in young people? *Psychology and Psychotherapy, 90*(3), 314–335. https://doi.org/10.1111/papt.12111.

Harwood, T., L'Abate, L., & SpringerLink (Online Service). (2010;2009). *Self-help in mental health: A critical review.* Springer, NY: Springer Science and Media https://doi.org/10.1007/978-1-4419-1099-8.

Holingue, C.; Badillo-Goicoechea, E.; Riehm, K.; Veldhuis, C.; Thrul, J.; Jognson, R.; Fallin, M.; Kreuter, F.; Stuart, E.; Kalb, L. (2020, October). Mental distress during the COVID-19 pandemic among US adults without a pre-existing mental health condition: Findings from American Trend Panel Survey. *Preventive Medicine, 139*, 106231–106231. https://doi.org/10.1016/j.ypmed.2020.106231.

Hossain, M., Asadullah, M., & Kambhampati, U. (2019). Empowerment and life satisfaction: Evidence from Bangladesh. *World Development, 122*, 170–183. https://doi.org/10.1016/j.worlddev.2019.05.013.

Hsiung, R. (2000). The best of both worlds: An online self-help group hosted by a mental health professional. *Cyberpsychology and Behavior, 2*(6), 935-950 DOI:10.1089/109493100452200.

Hymmen, P., Stalker, C., & Cait, C. (2013). The case for single-session therapy: Does the empirical evidence support the increased prevalence of this service delivery model? *Journal of Mental Health, 22*(1), 60–71. https://doi.org/10.3109/09638237.2012.670880.

Jost, J. T. (2020). *A theory of system justification.* Harvard University Press.

Jung, C. (2013). *The Undiscovered Self.* Routledge https://doi.org/10.4324/9781315850993.

Lear, J. (2015/2014). *Freud* (Second ed.). Routledge.

Leonard , K., Quesenberry, A. C., & Lindsay, J. M. (2015). Moderated social media support groups for patients. *Journal of Consumer Health on the Internet, 19*(3-4), 219–232. https://doi.org/10.1080/15398285.2015.1089397.

Lim, S., Powell, T. W., Xue, Q., Towe, V. L., Taylor, R. B., Ellen, J. M., & Sherman, S. G. (2019). The longitudinal association between perceived powerlessness and sexual risk behaviors among urban youth: Mediating and moderating effects. *Journal of Youth and Adolescence, 58*(8), 1532–1543. https://doi.org/10.1007/s10964-019-01027-w.

Lloyd, T. (2020, May/June). The efficacy of self-directed CBT curriculum. *American Jails, 34*(2), 40-44.

Lo, J., Rae, M., Amin, K., Cox, C., Panchai, N., & Miller, B. (2022, March 15). *Coronavirus (COVID-19).* (KFF, Producer) Retrieved May 7, 2022, from Telehealth Has Played an Outsized Role Meeting Mental Health Needs During the COVID-19 Pandemic: https://www.kff.org/coronavirus-covid-19/issue-brief/telehealth-has-played-an-outsized-role-meeting-mental-health-needs-during-the-covid-19-pandemic/

Lowe, C., Keown-Gerrand, J., Ng, C. F., Gilbert, T. H., & Ross, K. M. (2022). COVID-19 pandemic mental health trajectories: Patterns from a sample of Canadians primarily recruited from Alberta and Ontario. *Canadian Journal of Behavioural Science / Revue canadienne des sciences du comportement* https://doi.org/10.1037/cbs0000313, https://doi.org/10.1037/cbs0000313.

Mahapatra, S. (2020). Getting acquainted with virtual reality. *Journal of Humanities and Social Sciences Research, 2*(S), 17–22. https://doi.org/10.37534/bp.jhssr.2020.v2.nS.id1067.p17

Maslow, A. (1967). A theory of metamotivation: The biological rooting of the value-life. *The Journal of Humannnistic Psychology, 7*(2), 93–127. https://doi.org/10.1177/002216786700700201.

Mental Health America. (2020, 10 20). *2021 State of Mental Health in America*. Retrieved March 1, 2022, from Mental Health America: https://mhanational.org/issues/state-mental-health-america

Miguel, M., Ornelas, J. H., & Maroco, J. P. (2015, August 12). Defining psychological empowerment construct: Analysis of theree empowerment scales. *Journal of Community Psychology, 43*(7), 900–919. https://doi.org/10.1002/jcop.21721.

Nahai, F. (2018, October). Response to "Comments on 'The Stress Factor of Social Media'". *Aesthetic Surgery Journal, 38*(10), 153–153. https://doi.org/10.1093/asj/sjy162.

Narvaez, D. (2018). *Basic Needs, Wellbeing and Morality: Fulfilling human potential.* Cham, Swizerland: Palvrave Pivot https://doi.org/10.1007/978-3-319-97734-8.

Notredame, C. E., Grandgenevre, P., Pauwels, N., Morgieve, M., Vaiva, G., & Seguin, M. (2018). Leveraging the web and social media to promote access tocare among suicidal

individuals. *Frontier in Psychology, 9*, 1338–1338. https://doi.org/10.3389/fpsyg.2018.01338.

O'Connor, R., Wetherall, K., Cleare, S., Mc Clelland, H., Melson, A., Niedzwiedz, C., & Robb, K. (2021). Longitudinal analyses of adults in the UK COVID-19 mental health & wellbeing study. *The British Journal of Psychiatry, 218*(6), 326–333. doi:10.1192/bjp.2020.212.

Okon, S., & Webb, D. (2014). Self-determination: A curriculum of empowerment for health and wellness in a psychosocial rehabilitation clubhouse. *Occupational Therapy in Mental Health, 30*(2), 196–212. https://doi.org/10.1080/0164212X.2014.911672.

Pascual-Leone, A. (2009). Dynamic emotional processing in experiential therapy: Two steps forward, one step back. *Journal of Consulting and Clinical Psychology, 77*(1), 113–126. https://doi.org/10.1037/a0014488.

Perry, B. D., & Winfrey, O. (2021). *What Happened to You: Conversations on trauma, resilience, and healing* (First ed.). Flatiron.

Peterson, R. D., Grippo, K. P., & Tantleff-Dunn, S. (2008). Empowerment and powerlessness: A closer look at the relationship between feminism, body image and eating disturbance. *Sex Roles, 58*, 9–10. https://doi.org/10.1007/s11199-007-9377-z.

Reynolds, K., Medved, M., Dudok, S., & Koven, L. (2022). Older adults' mental health information preferences: A call for more balanced information to empower older adults' mental health help-seeking. *Ageing and Society*, 1–30. https://doi.org/10.1017/S0144686X21001896.

Roos, C., Silen, M., Skytt, B., & Engstrom, M. (2016, July). An intervention targeting fundamental values among caregivers at residential facilities: Effects of a cluster-randomized controlled trial on residents' self-reported empowerment, person-centered climate and life satisfaction. *BMC Geriatrics, 16*(1), 130–130. https://doi.org/10.1186/s12877-016-0306-2.

Rucker, D. D., & Galinsky, A. D. (2008). Desire to acquire: Powerlessness and compensatory consumption. *The Journal of Consumer Research, 35*(2), 257–267. https://doi.org/10.1086/588569.

Sampaio, M., Vicenta Navarro Haro, M., De Sousa, B., Vieira Melo, W., & Hoffman, H. (2021, January 15). *Therapists make the switch to telepsychology to safely continue treating their patients during the COVID-19 Pandemic. Virtual reality telepsychology may be next*. Retrieved May 7, 2022, from Frontiers in Virtual Reality: https://www.frontiersin.org/articles/10.3389/frvir.2020.576421/full

Sartorius, N. (2011). Empowerment and mental health. *European Psychiatry, 26*(S2), 21000–2100. https://doi.org/10.1016/S0924-9338(11)73803-2.

Satir, V. (1991). The Satir Model: Family therapy and beyond.

Saxon, D., Rickettts, T., & Heywood, J. (2010). Who drops-out? do measures of risk to self and to others predict unplanned endings in primary care counselling? *Counselling and Psychotherapy Research, 10*(1), 13–21. https://doi.org/10.1080/14733140902914604.

Schilling, C., Eisenberg, M., Kennedy-Hendricks, A., Busch, A., & Huskamp, H. (2022). Effects of high-deductible health plans on enrollees with mental health conditions with and without substance use disorders. *Psychiatric Services, 73*(5), 518–525. https://doi.org/10.1176/appi.ps.202000914.

Shea, S. (2017). *Psychiatric Interviewing: The Art of Understanding*. Philadelphia: Elsevier.

Tekleab, A., Sims, H., Yun, S., Tesluk, P., & Cox, J. (2008). Are we on the same page? Effects of self-awareness of empowering and transformational leadership. *Journal of Leadership & Organizational Studies, 14*(3), 185-201. https://doi.org/10.1177/1071791907311069.

Van der Kolk, B. (2014). *The Body Keeps the Score: Brain, mind, and body in the healing of trauma.* Penguin Books.

Venkatesh, A.K; Janke, A.T.; Kinsman, J.; Rothenberg, C.; Goyal, P.; Malicki, C.; D"Onofrio, G.; Taylor, Andrew; H.K. (2022, January 13). Emergency department utilization for substance use disorders and mental health conditions during COVID-19. *PLOS ONE, 17*(1). https://doi.org/10.1371/journal.pone.0262136.

Windle, E., Tee, H., Sabitova, A., Jovanovic, N., Priebe, S., & Carr, C. (2020). Association of patient treatment preference with dropout and clinical outcomes in adult psychosocial mental health interventions: A systematic review and meta-analysis. *JAMA Psychiatry (Chicago, Ill.), 77*(3), 294–302. https://doi.org/10.1001/jamapsychiatry.2019.3750.

Wolfers, L., & Utz, S. (2022). Social Media Use, Stress, and Coping. *Current Opinion in Psychology, 45*. https://doi.org/10.1016/j.copsyc.2022.101305.

Zhu, D.; Paige, S.; Slone, H.; Gutierrez, A.; Lutzky, C.; Hedriana, H.; Barrera, J.; Ong, T.; Bunnel, B.. (2021, July 9). Exploring telemental health practice before, during, and after the COVID-19 pandemic. *Journal of Telemedicine and Telecare*, https://doi.org/10.1177/1357633X211025943.

Biographical Statement of Author(s)

Rosenna Bakari earned a B.S. in Psychology from Cornell University, a M.S. from The State University of New York College at Brockport, and a Ph.D. in Educational Psychology from the University of Northern Colorado in 2000.

In addition to being a part-time lecturer at the University of Colorado Colorado Springs, she is an Empowerment Practitioner who designs and delivers affordable wellness programs for individuals and companies.

Dr. Rosenna Bakari "*Bestseller Author*"
(Author of "The Healing Journey," Amazon Bestseller)

Dr. Bakari welcomes inquiries and introductions at Rosennab@gmail.com or 719-203-9178.

Dr. Rosenna Bakari
Lecturer
Department of Counseling and Human Services
College of Education
University of Colorado
1420 Austin Bluffs Pkwy
Colorado Springs, CO 80918
U.S.A.

Email: Rosennab@gmail.com