*Special Issue: Introduction*

# Wellness, Prevention, *Development:* The Cornerstone of the Profession

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*The American Counseling Association's (ACA), formerly the American Association for Counseling and Development (AACD), unique contribution to a wellness philosophy lies in the profession's concern for development over the life span. In this article, ACA's commitment to and proactive stance toward wellness are described, the relationship between wellness, developmental approaches, and prevention is addressed, and the debate surrounding prevention as a non-third-party-reimbursable mental health service is discussed.*

## RESOLUTION: THE COUNSELING PROFESSION AS ADVOCATES FOR OPTIMUM HEALTH AND WELLNESS

WHEREAS, optimum physical, intellectual, social, occupational, emotional, and spiritual development are worthy goals for all individuals within our society; and

WHEREAS, research in virtually every discipline concerned with human development supports the benefits of wellness for both longevity and quality of life over the lifespan; and

WHEREAS, the AACD membership subscribe to values which promote optimum health and wellness;

THEREFORE, BE IT RESOLVED that the Governing Council of AACD declare a position for the profession as advocates for policies and programs in all segments of our society which promote and support optimum health and wellness; and

BE IT FURTHER RESOLVED, that AACD support the counseling and development professions' position as advocate toward a goal of optimum health and wellness within our society.

This resolution, adopted by the Governing Council of the American Association for Counseling and Development (AACD), now the American Counseling Association (ACA), on July 13, 1989, committed ACA to a proactive stance in relation to wellness issues. In this article I review the evolution and current status of ACA's involvement in wellness, including a discussion of the relationship of ACA's strategic planning process to the evolution of a professional philosophy oriented toward provision of developmental interventions. I conclude with a look toward the future in terms of preventive services and a review of the debate that has emerged concerning prevention and developmental interventions as non-third-party-reimbursable mental health services. This debate has led many in private practice to decry the increasingly developmental philosophy espoused by many ACA leaders.

## ACA AND WELLNESS: A HISTORICAL PERSPECTIVE

In an earlier article I suggested that wellness could become *the* paradigm for counseling and development (Myers, 1991). In examining what was meant by wellness, however, it seemed that this concept was not new to us at all but, rather, was deeply imbedded in the historical roots of our profession. We needed only to return to those roots to realize our unique contributions to the mental health field. Over the past few years, the profession and ACA have increasingly discussed and debated the place of a philosophy of wellness and developmental approaches as the means of achieving wellness. It is particularly timely now, as this special issue goes to press, to reexamine wellness and development and the nature of the paradigms upon which counseling is based.

After conducting an extensive literature review, Archer, Probert, and Gage (1987) concluded that wellness may be defined as "the process and state of a quest for maximum human functioning that involves the body, mind, and spirit" (p. 311). A variety of wellness models have been proposed, each reflecting in some manner the tenets of this definition. For example, Ardell (1988) described eight dimensions of wellness (psychological and spiritual, physical fitness, job satisfaction, relationships, family life, leisure time, and stress management), each of which may be perceived as addressing one or more aspects of the tripartite definition encompassing body, mind, and spirit. Hettler (1984) proposed a six-dimensional model, including intellectual, emotional, physical, social, occupational, and spiritual wellness. Other models are proposed in this special issue, each of which could serve as a basis for the development of helping interventions (e.g., Witmer & Sweeney, 1992).

A review of the historical development of the counseling profession (Gladding, 1992) readily reveals that career issues and a focus on working with children and young adults were among the earliest, most prevalent, and most consistent aspects of our profession. Farwell and Peters (1957) provided a definition of guidance for these populations that closely approximates the preceding definitions of wellness. They noted that guidance is " . . . based on the proposition that guidance workers are concerned with all aspects of development—psychological, physical, and social. To ignore the more complex social and moral issues that are of evident concern is to attempt only half the job" (p. 10). According to this definition, developmental guidance and a philosophy of wellness are, if not synonymous, at least closely intertwined.

Development traditionally *was* and now *is* seen as the core of guidance (Myrick, 1987). Furthermore, recent definitions of counseling also stress development as a core and integral concept (Ivey & Rigazio-DiGilio, 1991). Ivey (1991) stated that development is concerned with positive human change and actually is the goal of all counseling inter-

ventions. It is so integral to what we do that it becomes impossible to *do* counseling without stating or implying a developmental approach (Van Hesteren & Ivey, 1990). At the same time, Ivey argued the need for a paradigm shift if we are to actualize the benefits of the developmental approach. Prior to examining the basis of this argument, it may be helpful to review the current status of wellness within ACA, with a particular focus on activities and initiatives that emerged concurrent with or subsequent to the passage of the 1989 Governing Council resolution cited earlier.

## ACA'S COMMITMENT TO WELLNESS

In 1988 ACA embarked on a process of strategic planning that resulted in several products, including a mission statement and a set of nine goals that constitute the association's strategic plan. The mission statement reads as follows: "The mission of ACA is to enhance human development throughout the lifespan and to promote the counseling profession." Adopted by the Governing Council in 1989, and revised in 1992 to reflect the association's name change, that statement commits ACA to a proactive position relative to human development. A survey of ACA's membership revealed almost 98% agreement with this statement as descriptive of the association's mission (Nejedlo, Hansen, & Myers, in press).

The nine strategic planning goals address a variety of issues germane to the profession. Of most interest to this discussion is the goal titled "human development," formerly called the "developmental approach." The goal statement reads as follows: "To promote a developmental approach which will facilitate positive change and optimize human potential among the members' clientele" (AACD, 1991, p. 5). This goal is part of ACA's first strategic plan that was initially implemented in part in July of 1990 and subsequently fully implemented in July of 1991. The Governing Council agreed, based on the recommendations of the AACD Strategic Planning Committee, that the nine goals be renamed "fundamental purposes," and that these fundamental purposes (including the developmental approach) would not change within the foreseeable future. Each year, as part of the ongoing process of strategic planning, the purposes are reviewed and specific objectives are devised, with tasks, timelines, and responsible entities identified to ensure that progress is made toward achieving the intent of the fundamental purposes.

The problem statement that formed the initial basis for the association's purpose relative to human development reads as follows: "Currently, there is no clear AACD statement that delineates our position regarding the developmental (remedial, preventive, wellness) *approach to counseling and human development, which is the cornerstone of the profession*" [author's italics added] (AACD, 1991, p. 6). The needs identified to address the problem statement include "(1) a clearly articulated statement on the developmental approach to counseling and development, and (2) the implementation of this approach by educators and trainers in the field" (AACD, 1991, p. 6). Specific strategies (i.e., objectives) are identified to address these needs, including the development of an official ACA statement that explains the developmental approach and its use, dissemination of the position statement within ACA and to the public at large, encouragement of ACA entities, corporate affiliates, and related groups (e.g., Council for Accreditation of Counseling and Related Educational Programs [CACREP], National Board for Certified Counselors [NBCC], National Academy of Certified Clinical Mental Health Counselors [NACCMHC]) to adopt the developmental approach and create model programs that illustrate its use, encouragement of basic and applied research that tests the effectiveness of the developmental approach and expands our existing knowledge base, and encouragement of counselor educators to include instruction on developmental issues and principles of change in counselor training programs.

Concurrent with the development of ACA's strategic plan were 2 years of association themes that are directly relevant to this discussion. In 1988-1989 the association theme, "Transformations of the Profession," dealt with one aspect, which was the emphasis on refocusing our efforts toward a mission and strategic plan that included a commitment to developmental issues. The need for a paradigm shift (from illness to wellness) began to emerge as an issue within the ACA leadership in part as a result of this theme and the development of ACA's first strategic plan. The 1990-1991 theme, "Wellness Throughout the Lifespan," more directly addressed the issue of development and focused the association on the developmental approach as the underlying philosophical core that unifies our diverse profession. Moving into full implementation of the strategic plan, the 1992-1993 association theme "Diversity—Development—Dignity" further emphasizes this issue.

During the 1990-1991 association year, numerous articles appeared in the ACA *Guidepost* related to wellness. The ACA convention in 1991 was organized around the theme of wellness. Tapes of convention sessions are available through ACA headquarters and constitute part of our expanding information base relative to wellness. During that year also, many state associations, regions, and national ACA divisions adopted wellness as an annual theme. Conference presentations, newsletter articles, and the formation of wellness task forces within association entities are examples of the dissemination of the wellness theme throughout the association.

This special issue is also intended to address the need for knowledge of wellness issues and interventions for counselors. In addition, ACA has contracted for the development of a book on wellness, which will be widely advertised and disseminated through its publications department. The position statement on wellness should be published well in advance of the book and probably will be included in the appendixes to the book as an added means of dissemination.

It is impossible to discuss ACA's commitment to wellness without mentioning something about accreditation and certification. A review of the CACREP standards for counselor preparation readily reveals human development as one of eight core curricular areas for counselor preparation. Standards for school counselors prominently specify training in developmental counseling, and standards for training student personnel for higher education settings also address the need for training in student development. In fact, *student development* has become the preferred term to use when describing personnel working in higher education settings. The specialty standards for gerontological counseling that were adopted in March 1992 by CACREP also emphasize developmental issues as central aspects of curricular experiences. In addition, the criteria for certification by NBCC list human development as one of eight prerequisite areas of preparation. Specialty standards promulgated by NBCC for training career counselors, school counselors, and gerontological counselors all emphasize the critical role of developmental issues. It is clear that development is broadly infused into counselor training and certification and is widely acknowledged as having a central role within the profession. Still, we may lack common agreement of the meaning of development vis à vis counseling and the role played by developmental issues in the definition of our profession.

## THE MEANING OF DEVELOPMENT

As I was writing this article, AACD was preparing for a vote to change its name to the "American Counseling Association." Those who opposed the change argued that *development* is the core of what we *do* as

counselors. Those who favored the change frequently agreed with this argument but added that development is *so* central to what we do that it need not be a part of our title. Rather, our name should parallel other professional groups (e.g., American Sociological Association, American Psychological Association) in reflecting who we are—professionals who work in the field of counseling. There is no defined profession of human development.

Remley (1991) noted that the counseling profession has rejected the medical, illness-oriented model as the basis for our services. In defining what differentiates us as a separate and distinct mental health profession, he stated, "We do not believe that people must first be diagnosed with an illness before they can be treated with counseling services. Instead, we believe that all people can benefit from counseling . . . . Fully functioning people who experience everyday stress in their lives and those who are seriously mentally ill can benefit from a counseling philosophy that offers hope for a better tomorrow." The philosophy described by Remley is grounded in a developmental approach that focuses on prevention and wellness.

Closely related to Remley's notion is the view espoused by Ivey (1991) and his colleagues, who view a developmental orientation as "the identifying core of counseling" (Van Hesteren & Ivey, 1990, p. 524). Unlike Remley, Ivey believes that we *need to but have not yet* relinquished the medical model in favor of the educational-developmental model (Ivey & Rigazio-DiGilio, 1991). Ivey (1989) noted that our practice is to facilitate human development, which requires that we neither remediate nor prevent problems but, rather, cherish problems as opportunities for development and growth. Although problem resolution may be useful, it also may be unproductive: "A developmental focus leads toward increased personal growth and movement. Acceptance of life movement and the need for change is the issue, rather than static problem resolution. This could be the major distinction between the remedial and the developmental model" (Ivey, 1989, pp. 29–30). Ivey (1991) further noted that all problems may be redefined as developmental blocks, leaving the counselor and client to work together to effect developmental movement and change.

According to Remley, counseling has achieved a paradigm shift in terms of our philosophy. According to Ivey, we have yet to do so. A focus on prevention is actually consistent with both points of view, in that positive developmental growth and change is a key component for maintaining positive mental health. Healthy people tend to make healthy choices and decisions that enhance their life circumstances. In fact, one of the major benefits of a wellness orientation is that it enables people to make choices that are increasingly in their own best interest (Ardell, 1988). Thus, the greater the degree of mental health, developmental growth, or whatever one might call it, the greater potential for living life more fully. Positive developmental change at any point in life has an effect on the totality of the remaining life span—hence the concern among counselors for optimizing human development *now*, with the promise of a more fully functioning individual for the remainder of that person's life. For counselors working in elementary schools, the remainder of a life span could be close to 100 years! That's a long time for an impact to be felt, and certainly worth the effort of planning and implementing developmental interventions.

The World Health Organization estimates that 50% of all mental, neurological, and psychosocial problems could be prevented (L. Patt Franciosi, Chair, National Prevention Coalition, National Mental Health Association, personal communication, November 12, 1991). Prevention requires a new focus away from diagnosis and treatment of pathology—hallmarks of the medical model. Mental health receives less attention and fewer federal dollars than does physical health, which is also approached primarily from the perspective of the medical model. The recent national report, *Healthy People 2000*, notes that more than 75% of federal health care dollars are spent caring for persons with chronic illnesses, most notably heart disease, stroke, and cancer. Less than one half of 1% is spent to prevent these diseases from occurring (United States Department of Health and Human Services, 1990).

Given the strong link established between physical and mental health, it is conceivable that preventive mental health interventions can affect more than emotional wellness. Such interventions can promote physical wellness as well. Developmental, preventive, wellness interventions provided by counselors have the potential to have a significant impact on the incidence of mental as well as physical illness. Such effects would be felt across the life span of individuals. A significant question that must be addressed before this impact is realized is this: Can counselors succeed in the mental health marketplace if our paradigm is clearly one of enhancing wellness (prevention, developmental growth and change) rather than remediation of illness?

## PREVENTION: A GOAL FOR THE FUTURE

ACA and the profession it represents have been experiencing growing pains. Training standards, training program accreditation, certification, and licensure, among other developments, have contributed to the growth of the profession. Uniform support for these hallmarks of professional growth does not exist. For example, I was criticized by colleagues for using professional credentials in my signature block on official correspondence. Organizations such as CACREP have been openly criticized for their standards, procedures, and goals. In addition, ACA members and leaders continue to discuss the issue of specialization, with critical comments addressed to the proliferation of specializations and seeming fragmentation of the profession. When studied in depth, these issues tend to coalesce around the concept of *identity*. Challenged from within as well as without, ACA is facing the need to define who we are, whom the association represents, and what it is that makes us unique as service providers in the mental health arena. Inherent in the definition of our profession is a widely recognized philosophical foundation, a foundation that is espoused by some yet not accepted by all. It revolves around the meaning and intent of the word *development*, which incorporates concerns for prevention of illness and the enhancement of wellness throughout the life span.

The arguments in favor of prevention are compelling to some, yet they are viewed differently through the lenses of those who ascribe to the medical model. Because the medical model predominates with third-party reimbursement sources, counselors whose livelihoods depend on third-party payments cannot eschew the illness orientation. They must, if not embrace it, at least understand and be able to apply it. Links between diagnoses and developmental approaches (see Ivey, 1991) are so new as to be termed *cutting edge* topics in the counseling field. Counselors in private practice may or may not seek training to examine the links, at least not on a wide scale and not until the profession is able to clearly articulate the developmental approach, and to assist in elevating prevention to the same status as remediation with third-party payers.

Those in private practice argue against persons such as Remley and Ivey, noting that claims for the unique identity of counseling as related to the developmental approach threaten the ability of private practitioners to receive third-party reimbursements based on the medical model (see Pitts, 1991). Robinson (1990) suggested that Van Hesteren and Ivey "appear to be presenting their ideas in a vacuum with respect to . . . the limitations of insurance coverage" (p. 530). Certainly it is true, *at this time*, that few insurance providers reimburse for preventive services. It

is *not true*, however, that we must be bound by what now exists, and it *is true* that developmental interventions can be used to treat pathology (see Ivey, 1991). If counselors truly believe in the value of prevention, then we need to redirect our public relations and advocacy efforts toward ensuring equitable reimbursement for developmental interventions as now exists for diagnosis and treatment of mental disorders. We need to fully explore and apply Ivey's (1991) model for applying developmental interventions with clients for whom a *Diagnostic and Statistical Manual of Mental Disorders* revised edition *(DSM-III-R)* diagnostic category is appropriate. In short, we need to do what we do best, with a sense of pride and the knowledge that what we do actually works.

Furthermore, we need to examine carefully the double message we are providing to ourselves, to counseling practitioners, and to students when we fight for a piece of the pie dictated by the medical model, while at the same time promoting our services as oriented toward wellness. We hold to the marketplace value of the medical model while asserting that the developmental model is uniquely ours. In short, we *do* need to achieve the paradigm shift discussed by Ivey, Remley, and others. We *do* need to commit ourselves to a wellness model rather than an illness model.

It will be difficult for the profession to embrace an identity based on developmental, wellness, preventive approaches unless we can prove the value of our services to ourselves as well as to others. We do not have the luxury of waiting for longitudinal research that shows the benefits of developmental interventions across the life span. We need outcome research studies *now* that show the positive effects of wellness interventions on individuals and society. It is hoped that the articles in this special issue will provide both a baseline of knowledge and a stimulus for research in this area.

## REFERENCES


American Association for Counseling and Development. (1991). *AACD strategic plan.* Alexandria, VA: Author.

Archer, J., Probert, B. S., & Gage, L. (1987). College students' attitudes toward wellness. *Journal of College Student Personnel, 28*(4), 311–317.

Ardell, D. B. (1988). The history and future of the wellness movement. In J. P. Opatz (Ed.), *Wellness promotion strategies: Selected proceedings of the eighth annual National Wellness Conference.* Dubuque, IA: Kendall/Hunt.

Farwell, G., & Peters, H. J. (1957). Social-personal issues: Guidance implications. *Understanding the Child, 26*(4), 110–112.

Gladding, S. (1992). *Counseling: A comprehensive profession* (2nd ed.). New York: Macmillan.

Hettler, B. (1984). Wellness: Encouraging a lifetime pursuit of excellence. *Health Values, 8*(4), 13–17.

Ivey, A. (1989). Mental health counseling: A developmental process and profession. *Journal of Mental Health Counseling, 11*(1), 26–35.

Ivey, A. (1991). *Developmental strategies for helpers: Individual, family, and network interventions.* Pacific Grove, CA: Brooks/Cole.

Ivey, A., & Rigazio-DiGilio, S. A. (1991). Toward a developmental practice of mental health counseling: Strategies for training, practice, and political unity. *Journal of Mental Health Counseling, 13*(1), 21–36.

Myers, J. E. (1991). Wellness as *the* paradigm for counseling and development: The possible future. *Counselor Education and Supervision, 62*(3), 3–10.

Myrick, R. (1987). *Developmental counseling.* Minneapolis, MN: Educational Media Corp.

Pitts, J. (1991, December). Letter to the editor. *Guidepost,* p. 2.

Nejedlo, R., Hansen, S., & Myers, J. E. (in press). Strategic planning for AACD. *Journal of Counseling & Development.*

Remley, T. (1991, August). On being different. *Guidepost,* p. 3.

Robinson, S. (1990). Is counseling the same as development? A response to Van Hesteren and Ivey. *Journal of Counseling & Development, 68,* 529–531.

United States Department of Health and Human Services. (1990). *Healthy people 2000: National health promotion and disease prevention objectives.* Washington, DC: U.S. Government Printing Office.

Van Hesteren, F., & Ivey, A. E. (1990). Counseling and development: Toward a new identity for a profession in transition. *Journal of Counseling & Development, 68,* 524–528.

Witmer, J. M., & Sweeney, T. J. (1992). A holistic model for wellness and prevention over the life span. *Journal of Counseling & Development, 71,* 140–148.



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