

Wellness as the Paradigm for Counseling and Development: The Possible Future

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Article:

Wellness refers to the maximizing of human potential through positive life-style choices. This holistic paradigm offers a philosophical base for counseling and development that provides guidelines for intervention and at the same time emphasizes the uniqueness of our approach as counseling and development professionals to mental health concerns. The author advocates a wellness paradigm rather than the illness-oriented medical model as being most reflective of our profession.

Wellness could become the paradigm for counseling and development. This article examines six premises that suggest that we (as professionals in counseling and development) already are engaging in wellness interventions. What we need to do next is to affirm our commitment to a wellness philosophy as the core of what we do in counseling and development.

PREMISE 1: WELLNESS IS NOT NEW

Wellness has been defined as "the process and state of a quest for maximum human functioning that involves the body, mind, and spirit" (Archer, Probert, & Gage, 1987, p. 311). Such a concept clearly is not new to those of us in the field of counseling and development. For example, Farwell and Peters as early as 1957 defined guidance as ". . . 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). Counseling as we know it today evolved from early models of guidance that emphasized development to current models of counseling that emphasize development (Ivey & Rigazio-DiGilio, 1991; Myrick, 1987). In talking about wellness, then, we may be subject to criticism for using semantics to create a new mystique with old material.

Conversely, the wellness movement could be viewed as the proverbial swinging of the pendulum. Significant changes in the counseling and development professions within the last three decades, and in particular the last 20 years, include greater attention to the needs of persons across the life span and increased provision of counseling services in community as well as school settings. As counselors have increasingly competed with other community mental health care providers for a share of the marketplace, the temptation has been to "prove" that we are equal in terms of training, skills, and methods. We have moved away from developmental theories in an attempt to prove our equality in the treatment of pathology. As a result, our unique contributions to mental health care often are overlooked and underemphasized. I believe it is timely to reexamine our roots, clarify our identity, and develop and publicize a statement of roles that places the members of our profession at the forefront of what we do uniquely and best--optimizing human potential through a wellness-oriented philosophy.

A brief review of definitions of wellness, components and outcomes of wellness programs, and various wellness and illness paradigms may provide clues to how wellness interfaces with counseling and development at this point in time. This information provides a background for the conclusion that wellness should become the paradigm for counseling and development--that we should, in fact, become prime advocates for wellness. Counselor educators can play a key role in bridging the gap between our current, fragmented philosophy and the possible, integrated philosophy of the future.

PREMISE 2: WELLNESS IS NOT SYNONYMOUS WITH HEALTH

Wellness refers to a merging of body, mind, and spirit (Stiles, 1984), with an emphasis on a balanced life-style as both a process and a goal (Warner, 1984). Ardell (1988) defined wellness as "a conscious and deliberate approach to an advanced state of physical and psychological/spiritual health" (p. 5).

Several different wellness models have been proposed, the most basic being the tripartite definition of wellness as the holism that results from consideration of physical, mental, and spiritual aspects of functioning. Ardell (1988) described eight areas or dimensions of wellness: psychology and spirituality, physical fitness, job satisfaction, relationships, family life, nutrition, leisure time, and stress management. Hettler (1984) proposed a six-dimensional model incorporating the areas of intellectual, emotional, physical, social, occupational, and spiritual wellness. Witmer and Sweeney (in press) suggested the need for examining multiple life roles as components of a wellness life-style. Ten characteristics of wellness and four life tasks are presented as interacting in creative and dynamic ways to assist effective coping with stress as well as nurturing one's potential for well-being. Components of this model are presented in an integrated way while providing illustrative multidisciplinary research in support of the model.

Greenberg (1985) noted the importance of distinguishing between health and wellness. He defined health as consisting of social, mental, emotional, spiritual, and physical components. Wellness is the integration of these components, and high level wellness results when all of the components are in balance. Health has been defined as the absence of illness. Wellness goes far beyond this point and emphasizes a zest and enthusiasm for life. With a holistic focus, wellness incorporates not just the whole person, but the whole person throughout the totality of the life span. Wellness is not a one-shot effort, a here-and-now philosophy. It promises an enhanced life-style, beginning at any point when deliberate, conscious choices toward wellness are made. Given the integrated nature of human functioning, any positive changes made in any one aspect of functioning will lead to enhanced functioning in all areas. Furthermore, "people can be well regardless of whether they are ill or healthy" (Greenberg, 1985, p. 404).

Rogers's (1961) description of the whole person and Maslow's (1970) description of self-actualization may seem close to the definitions of wellness provided here. These concepts, however, seemingly exclude physical health or downplay its importance (Archer, Probert, & Gage, 1987). In describing a holistic wellness philosophy, Hettler (1984) stressed that this is a proactive approach in which individuals enhance the quality of their lives through progressively responsible choices for self-care. Clients are helped to become more self-sufficient and experience a sense of empowerment that allows them to choose and maintain more healthy life-styles. These goals are seemingly quite consistent with general counseling goals, leading to the tentative conclusion that wellness and counseling are not far apart even at this point in time. Where they differ most is in application.

PREMISE 3: WELLNESS PROGRAMS ARE COST EFFECTIVE

The financial loss due to specific health problems, such as alcoholism, costs industry an estimated \$15 billion annually, and premature employee death costs American industry \$19.4 billion a year--more than the combined 1976 profits of Fortune's top five corporations.... industry pays twice for the cost of health care: first through insurance premiums and then through the economic burden for employee absenteeism, turnover, retraining, and premature death. (Reza-Forouzesh & Ratzker, 1985, p. 20)

Wellness and health promotion programs in industry have become popular as a means of decreasing employee health care costs. The most common program is weight reduction, followed by smoking cessation and hypertension screening and treatment. The various types of programs include health and fitness assessments for high stress-level executives, lectures on health care, health improvement clinics, exercise facilities, economic incentives, and mental health programs (Feuer, 1985).

Feuer (1985) noted that evaluation studies of wellness programs, although difficult, have yielded several important findings. First, high risk factors for cardiovascular illness, including smoking, obesity, and lack of

exercise, can be treated through wellness programs with a high cost-benefit ratio. Second, the effects of hypertension have been reduced 20%-50% when diagnosed and treated in the workplace. Third, smoking cessation programs yield 6-12 month abstinence rates for 15%-60% of the workers. Fourth, weight control programs yield high success rates, particularly when competition and team work are used as incentives. Fifth, after 1 year of physical fitness programs, major medical costs for participants dropped 45.7%, with the average number of disability days decreased by 20.1%, which is a 31.75% reduction in direct disability costs.

While the education and background of staff in wellness programs vary, Reza-Forouzes and Ratzker (1985) found that staff were primarily nurses (61.4%) or physicians (45.7%). Psychologists composed 20% of staff, and social workers 11.4%. Counselors were not mentioned in their study. However, among the major types of health and wellness programs offered by Fortune 500 companies, these authors provided the following ranking: weight reduction (85.7%), smoking cessation (84.3%), high blood pressure safety (80.0%), nutrition education (70%), alcohol and substance abuse (67.1%), stress reduction and control (61.4%), personal health (55.7%), and general life-style education (55.7%). Many of these programs fall within the purview of services provided by counselors.

Feuer (1985) listed "mental health program and incentive systems" (p. 26) as one of six benefits of employee wellness programs. He described employee assistance programs as promoting the mental health of workers through "a relatively low cost counseling and referral service" (p. 30). Short-term counseling is the focus of such programs, which have an overall goal of turning the locus of control back to the individual. Several years ago, Petrosa (1984) reviewed these and other benefits of wellness programs and declared that "wellness might be characterized as a movement in search of a qualified profession" (p. 39). He also noted that the International Union of Health Education in 1981 declared health education to be "the primary profession responsible for wellness and quality of life" (p. 31). What then, we might ask, could be a possible role for counselors in the wellness movement, 10 years later?

PREMISE 4: A PARADIGM SHIFT IS NOT REQUIRED

Barker (1988) defined paradigms as schemata that establish our boundaries for action and set rules for successful outcomes. They act as filters, screening out data that do not fit our preconceived notions of how life should be. In some ways, the paradigms to which we adhere can limit our perceptions of the future, binding us to what occurred in the past. Barker provided an example in describing the watch-making industry. In 1968, Switzerland controlled 65% of the market in watches and over 80% of the profits. In 1990, Japan, which had no share of this market in 1968, controlled the overwhelming share of the market and profits. Why do the Swiss no longer control the market? They refused to consider the new concept (read as paradigm) of quartz crystal movements, which are about 1,000 times more accurate than the old-style clocks. The success of the Swiss in the past effectively blocked their ability to perceive another way to do things in the future. Barker referred to the Swiss as suffering from paradigm paralysis—a disease of certainty. This is an interesting concept to consider when suggesting that counselors adopt a wellness paradigm as the basis of what we do. In many ways we already have done so; in others we refuse to do so.

Four general models or paradigms of helping guide interventions in mental health today (Ivey & Van Hesteren, 1990). The first, the medical model, emphasizes organic pathology, remediation, and repair by external authorities. The second, the psychological model, focuses on the mind and treatment of individual pathology. The third, the family systems model, focuses on the individual in context. The last model, the educational-developmental model, considers both medical and psychological aspects of functioning but differs from the other models in its emphasis on a systems approach in which human potential unfolds through interactions with families, groups, organizations, and culture. The counseling and development profession has strong roots in the medical and psychological models, orientations recently questioned for not standing the test of time. Ivey and Rigazio-DiGilio (1991) argued that we are facing a paradigm shift in terms of conceptions of the helping process and that we must move from a medical to an educational-developmental model.

If developmental guidance is indeed the historical foundation of counseling and development, as discussed earlier in this article, then a paradigm shift such as that proposed by Ivey and Rigazio-DiGilio (1991) really is not needed. The focus of helping interventions in counseling and development already is on prevention as well as remediation, on wellness along with treatment of pathology. In fact, this focus is what makes us unique among the helping professions. Unfortunately, the wellness emphasis is not well understood and not systematically taught or applied. There is a divergence of opinion within our profession as to our ultimate goals. The current reality of third-party payments, rooted in the medical model, causes some to argue the need for further emphasis on pathology in counselor training. Those whose concern is with "developmental interventions" are seen as practicing outside of a "mental health" environment. Such a stance is primarily reactive rather than proactive in addressing mental health issues.

The wellness paradigm incorporates a developmental emphasis stressing prevention, the phenomenon of choice, and the optimization of human functioning. It is an inclusive paradigm that requires an examination of self, family, group, society, and other systems, as well as the environment, as enablers or detractors of the pursuit of wellness. This paradigm has intrinsic to it a systems approach that goes beyond the limits of interpersonal or social systems. In doing so, it provides a framework for holistic interventions. Unfortunately, many counselors deny the importance of such an approach to mental health interventions. Arguments I have heard include statements such as the following: "As counselors, we cannot do anything about spiritual concerns, so we should not address these in training or practice"; "I would never think to discuss my client's obvious weight problem unless he or she brings it up first"; "the environment is beyond our control"; and "we are not nutritionists or physicians, so we should not discuss such matters with our clients." These same individuals become distressed when "everyone" claims to be "a counselor."

The wellness paradigm does not in any way negate or ignore pathology; however, in terms of treatment, alternatives to pathology are offered. Persons experiencing significant dysfunction may need illness-oriented forms of treatment, but at the same time the goals of intervention focus on holistic development, positive choices, and satisfying life-styles. Again, the absence of illness is not the goal, but optimum functioning across the life span is. What is intriguing about this approach is the promise of change, which multiplies its effect in a positive manner over the course of the life span. Thus, there really is no time in life at which choices for wellness will not have a beneficial effect spanning the totality of the life span. Because wellness choices enable and empower persons to make choices that increasingly are in their own self-interests (Ardell, 1988), the impact of such choices has a multiplier effect.

PREMISE 5: WELLNESS AND COUNSELING ARE ALREADY PARTNERS

The mental health component of existing wellness programs is probably understated. The strong link between physical and mental health leads to emotional benefits as a by-product of wellness programs. Ultimately, the potential exists for mental health to be a direct target of wellness interventions. The foundation exists; it needs only to be further developed and implemented. Is it acceptable that health educators are claiming to provide the counseling needed in wellness programs? I think not.

The mission of the American Association for Counseling and Development (AACD) is "to enhance human development over the life span and to promote the counseling and development profession" (AACD, 1990b, p. 4). The Council for Accreditation of Counseling and Related Educational Programs requires human development as one of eight core curricular areas for counselor preparation. National and state certification standards require training in human development for those who would practice as counselors. And, developmental emphases are increasingly stressed as the core of what we do as counselors (Ivey & Van Hesteren, 1990; Myrick, 1987). The focus of developmental interventions is on helping individuals negotiate and cope with normal developmental challenges and tasks. The goal is to help individuals learn and integrate the skills necessary to cope with life effectively, with the ultimate goal of optimizing the developmental potential for each human. Is this not exactly what we do as counseling and human development specialists? Perhaps we need not to change to a wellness philosophy, but rather to affirm the historical roots of our

profession and the prevalent wellness orientation that even now forms the foundation for what we do in counseling and development.

PREMISE 6: IT IS TIME TO BE NOTICED FOR WHAT WE ARE DOING

Clearly, there is a need to clarify what it is counselors do and do well if we are to achieve the status we seek as providers of mental health care. We need to stop fighting with the other mental health professions for a piece of their pie and focus instead on what it is that we can do that makes us viable in the mental health marketplace. This includes remedial interventions but is not limited to this area. Furthermore, what we can do goes far beyond linking physical exercise with counseling, although even this small step has proven to have major positive benefits (Childers & Burcky, 1984; Hinkle, 1988).

I find it interesting that publicity has made physical health a decided priority in our society, but the same effect has not occurred for mental health. In 1988, sales of oat bran in the United States were \$9.9 million. In January of 1989, the *New England Journal of Medicine* published the results of a study stating that oat bran lowered cholesterol. Within the next year, sales of oat bran increased to \$72.2 million (*USA Today*, 1990). Consider the possibility of the following scenario:

In the near future, the *Journal of Counseling and Development* publishes a study revealing that the effects of child abuse are lifelong and result in dysfunction and perpetuation of the family cycle of violence, as well as general unhappiness. This same article, however, notes that it is possible for counselors to treat both the abusers and the abused, resulting in significant improvements in mental health, Happiness, success, and quality of life for both children and abusers--over the course of the entire lifetime of each individual. Within the next 12 months, the demand for counselors cannot be met, as families with abusive behaviors voluntarily seek them out to ask for treatment. And, the costs of such treatment are covered by third-party reimbursement.

Is the scenario described here only a dream, or could it really be the possible future? Are we willing to set some realistic short-range goals that could lead us in this long-range direction? I think we should, not just because wellness is an inclusive, systemic approach to optimizing human development; not just because it may lead to healthier life-styles for individuals, groups, society, and the environment; and not just because wellness--developmental counseling, prevention, call it what you will--works. I think we should because we already are. But, we are doing it piecemeal, quietly, cautiously, and only sporadically with enthusiasm. We hesitate to identify with the physical, medical, or spiritual aspects of wellness. We fear that any deviation from the medical model will result in a termination of the third-party reimbursements that we are fighting so hard to achieve. We have, now, the opportunity to truly carve out our niche in the mental health field, to become prime advocates for wellness. To accomplish this, we need to take action steps such as the following:

1. We must develop and articulate a statement defining the wellness philosophy that simultaneously provides a statement of identity for those in our profession.
2. We must examine our role vis-a-vis health educators in determining our share of the wellness marketplace. Can we afford to engage in another series of turf battles as we have with the other mental health providers? Is there a way to develop cooperative alliances that strengthen rather than dilute our role? We need to explore and find answers to these questions.
3. We must modify counselor training, and counselor preparation standards, to incorporate a wellness philosophy. This needs to extend beyond curricular experiences in human growth and development and be infused in all aspects of counselor training.
4. We must modify credentialing criteria to incorporate the wellness philosophy as infused in professional preparation programs.

5. We must engage in significant research on methods and outcomes of wellness interventions. We need longitudinal studies to prove the long-range impact of prevention and treatment using a holistic, wellness paradigm.
6. We must actively advocate for wellness programs with a mental health component and for a wellness philosophy that serves as an enabler of program and individual development.
7. We must actively advocate with third-party payers of reimbursements for prevention interventions. The economic incentives alone are a motivator in this regard.
8. Last, but surely not least, we must take pride in a paradigm that establishes our unique contributions as resulting from a commitment to a philosophy of wellness. To achieve this end, we need to start at home, with the development of wellness life-styles in ourselves and our families. We cannot promote what we do not first believe and model. If wellness truly is a goal for our clients, it must be one for each of us as well, and in all the various systems in which we function.

For our profession, it is time to commit ourselves fully to the intent of the following resolution, approved by the AACD Governing Council in March 1989:

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, there are many indications that there is growing support in business, industry, education, and government for attitudes, values and practices related to wellness; 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. (AACD, 1990a, p. XIV-8)

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