

HEALTH AND WELLNESS – CONCEPTUAL GROUNDING

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Abstract

In nowadays, it is generally understood that human health lies beyond the physical body, which had been the primary focus of medicine for centuries. In 1941, Sigerist wrote, "health is not simply the absence of disease: it is something positive, a joyful attitude toward life, and a cheerful acceptance of the responsibilities that life puts upon the individual (Sigerist, 1941). This development in the understanding of health was underlined by the actual state of human health in the mid-20th century, when the human population struggled less with communicable diseases and more with lifestyle related condition. The modern approach to health aimed to clarify the traditional understanding of it that emerged over several centuries during which people collected health-related knowledge in the form of folk medicine treatments. The aim of the theoretical study is to give a broader background and perspective on the term health, examining it through the lens of Kinanthropology, approaching it from the positive perspective of human flourishing. The main research question states: "What can one do to feel better?" and the answer could be to "Live healthier." Wellness emerged as a new term that would broaden the focus from physical health and would integrate the body, mind and spirit of an individual within the social context in which they exist, while empowering them to take responsibility for the state of their health at any given moment.

Keywords

Life style, Wellness. Interventions, WHO, Health, Disease, Disability

1 INTRODUCTION, BACKGROUND

1.1 Perception and definition of health

Throughout human history, the pursuit of health has been among the primary aims of individuals, communities, national governments and international initiatives. The first Czech president Tomáš Garrigue Masaryk said: "Health - a healthy mind and a healthy body - it is ultimately the aim of all politics and administration" (Fišer, 2014).

Hand in hand with the never-ending pursuit of health go numerous attempts to define health. This idea is built on the

presumption of modern science - once we define a specific phenomenon, we can measure it, clearly understand how it functions and suggest operational steps towards support or elimination of it. This modern approach to health aimed to clarify the traditional understanding of it that emerged over several centuries during which people collected health-related knowledge in the form of folk medicine treatments. The point was to make humans healthier; but as the report *Doing better, feeling worse* showed, the development of society and technology in the context of the past two hundred years have brought scientific

approaches and methods which have unravelled and explained almost all the mysteries of human body and its diseases. Yet, the state of full health is still not a common trait (Knowles, 1977b).

Today, it is generally understood that human health lies beyond the physical body, which had been the primary focus of medicine for centuries. In 1941, Sigerist wrote, "health is not simply the absence of disease: it is something positive, a joyful attitude toward life, and a cheerful acceptance of the responsibilities that life puts upon the individual (Sigerist, 1941, p. 100)." This development in the understanding of health was underlined by the actual state of human health in the mid-20th century, when the human population struggled less with communicable diseases and more with lifestyle related conditions. It was no longer in the capacity of a medical practitioner to make his patient healthier; instead, a multidisciplinary lifestyle approach to the phenomenon was called for. The modern definition of health by the World Health Organization clearly formulates the need:

"Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." (World Health Organization, 1948)

This positive definition of health was a response to the negative perception of a healthy human as a person not having a physical disease or any sort of mental illness (Larson, 1996) and in the eyes of many created a conception of health seen as an ideal (Schramme, 2007).

According to this definition, health is differentiated from health status. According to Breslow (2006), health has a multidimensional and dynamic potential for improving or at least maintaining whatever

health status a person has. He argued that, more than achieving some degree of health status, people want health as a resource for doing the things they want to do. Larson (1996) points out that this definition was created after World War II, during a period when the social health of societies was in question. Broadening the concept of health beyond an individual's physical health towards the social aspect of it allowed for the rise of new professional areas of health promotion and public health in the second half of the 20th century.

With respect to the complexity of different perspectives on human ailments and flourishing, we agree with Hofmann (2002), who asserts that it is very difficult, if not impossible, to give strict definitions of basic concepts within modern health care. In recent decades, there have been numerous concepts of health developed in the context of different needs and objectives. These range from a theorist's perspective of health as a striving for conceptual clarity, to more fully operationalizing it via actual medical practice approaches, and beyond to those concerned with wider policy and health-promotion issues in the global context (Law & Widdows, 2008; Sartorius, 2006).

In order to trace the cultural differences in individual perception of health, we use the WHO definition mostly for its conceptual clarity, global recognition and its frequent use in health promotion across public, private and scientific sectors. While respecting the authority of the WHO, we acknowledge some limitations of the definition and work with further refinements of it:

1. The WHO definition of health has been criticized for being overly idealistic and non-operational in

practice. Critics argue that this definition defies measurement, may be unattainable in reality, and marginalizes people with disabilities and groups that view health and well-being as a collective construct (Mittelmark & Bull, 2013; Üstün & Jakob, 2005; Wilson & Hopkirk, 2014; Yach, 2013). Also using the term well-being is by some authors seen as broad and conflating the concepts of health and happiness (Callahan, 1973; L. Frank, 2013; Richards et al., 2015).

2. In particular, due to the use of the word “complete” which implies absolute physical, mental, and social well-being as one of the fundamental rights of every human being, this definition is being seen as somewhat purist, vague and unattainable view of health. (Jadad & O’Grady, 2008; Kristén, Ivarsson, Parker, & Ziegert, 2015; Larson, 1996) It is hard to achieve and/or maintain a state of complete well-being in all dimensions. It is more likely that one experiences highs and lows in different dimensions simultaneously, such as when an individual who is physically healthy yet struggles with relationships or spiritual pursuits, or some other area of his or her lifestyle.
3. Another criticism calls for an adjustment of the WHO definition of health by adding spiritual health to the current three dimensions – physical, mental and social. Research supports arguments that spirituality is part of health and not

merely an influence (Larson, 1996), as it contributes to mental and physical health in many persons in their recovery, wellbeing and longevity (Association of American Medical Colleges, 1999; Grant, 2007; Lucchetti et al., 2012). Interventions based on mindfulness and meditation practice have become increasingly popular (Ngô, 2013), prayer is recognized among the most used among the top ten complementary and alternative medicine therapies (National Center for Complementary and Integrative Medicine, 2004) and schools teach courses or content on spirituality (Briggs, Akos, Czyszczonek, & Eldridge, 2011) and health and indicated that patients emphasize spirituality in their coping and health care (Koenig, Hooten, Lindsay-Calkins, & Meador, 2010; Lucchetti et al., 2012; Neely & Minford, 2008).

There is still a lack of common agreement about the spiritual dimension of health across the scientific paradigm (Larson, 1996) and further steps need to be taken for recognition of spirituality as a valuable factor of human health. The discussions have already started. In 1984, the World Health Assembly adopted resolution WHA37.13 which made the spiritual dimension a part of WHO member states’ strategies for health (World Health Organization, 1984) and in January 1998, the Executive Board adopted resolution EB 10 1.R2 (World Health Organization, 1998) recommending that the World Health Assembly adds the word “spiritual” to the definition of health in the

preamble to their constitution and the global health-for-all policy (Khayat, 1999). Spirituality has therefore gained recognition in the health field, and professionals, institutions and countries are encouraged to include the spiritual dimension in their health policies and strategies, recognizing it as a fundamental part of health promotion. Note: At this writing, the WHO assembly has still not changed the definition of “health” in the WHO’s constitution.

1.2 Illness, disease and sickness

Speaking about health in a broader perspective, the former physical notion of health has different meanings across various areas of the natural and social sciences. It is argued that disease, illness, and sickness represent different perspectives on human ailments that can be applied to analyze both epistemic and normative challenges to modern medicine. Points of cultural variation with respect to health involve ideas about nosology, aetiology, and therapy, or, more simply, the kinds of illnesses, how and why they occur, and what can be done about them (Basch, 1989; Hofmann, 2002).

Disease is a malfunctioning or maladaptation of biologic and psychophysiological processes in the individual (Kleinman, Eisenberg, & Good, 2006). In this approach, the focus lies on the patient’s body rather than on the whole person. Disease belongs to public health and is described in the official roster of western, scientifically recognized syndromes - the International Classification of Diseases. Its frequent revisions show that recognized types of diseases are continually changing as scientific knowledge increases and

information becomes available (Basch, 1989; Gatchel & Kishino, 2012).

In the Western biomedical model, illness is explained in terms of a patient’s presenting pathophysiology. Illness is the matter of medicine and its challenge lies in the fact that all illnesses are individual and each is unique (Basch, 1989). Illness is a personal, interpersonal and cultural reaction to disease or discomfort. It can be seen as the person’s experience of being sick and is reflected in the person’s thoughts, feelings, and altered behaviors, within the context of his or her culture. It means, that people can have illness, but not the disease, as they might have yet developed only its symptoms (Kleinman et al., 2006). To understand a patient’s experience of illness, we must attempt to enter the patient’s world, to understand the patient’s beliefs about what is wrong, why it happened, and what should be done (Kline & Huff, 2008; Weston, Brown, & Stewart 1989).

Sickness is the terrain of social science. An illness transforms a healthy person into a sick person. Being sick is a socially recognized state regardless of the details of the particular cause or ailment, carrying with it certain specific obligations and privileges (Basch, 1989). The sociologist Talcott Parsons has examined the relation of the problem of health and illness as the deviance from the capacity to perform expected tasks and roles. In this he is aligned with current researchers and professionals that see health as human capability and optimal functioning (L. Frank, 2013; Law & Widdows, 2008; Tengland, 2007; Venkatapuram, 2013). Parson’s sick role concept has become challenged in the face of the increased significance of chronic illnesses and the

growing emphasis on lifestyle-centred health promotion that has shaped the focus of medical sociologists towards applied health behaviour (Basch, 1989; Burnham, 2014; Varul, 2010).

The above-mentioned terms can mean minor differences in the general spoken language, but outline three different scientific approaches. Moreover, they illustrate the need for a multidisciplinary approach to health oriented studies.

1.3 Lifestyle

Individual behaviour patterns, or personal “lifestyle”, represent the single most controllable and also one of the most threatening domains of influence over human health (Koop, Pearson, & Schwarz, 2002). Lifestyle is “the typical way of life of an individual, group, or culture (Merriam Webster Dictionary, n.d.)” Jansa defines lifestyle as a dynamic process of individual’s being that is determined by genetic, ethnical, social, cultural, professional and generational factors (Jansa & Kovář, 2010).

A review of recent scientific literature, conducted by author and published in 2016 (Stará & Charvát, 2016), revealed that healthy lifestyle is not a clearly defined concept, yet in their articles authors agree on recommended behaviors that foster human flourishing: daily physical activity at optimal levels, healthy diet and nutrition, maintaining a healthy body weight, and preferably not smoking or abusing alcohol. The term is well established and commonly used in the scientific paradigm due to its measurability and scientifically proven impacts on physical health (Arena et al., 2016; Centres for Disease Control and Prevention, n.d.; Ottevaere et al., 2011;

The American Heart Association, n.d.; World Health Organization, 2015). Research that examines the combined effect of lifestyle factors on physical health is plentiful and data have been gathered by Loef and Walach (2012) in a meta-analysis that validated that adherence to a healthy lifestyle is associated with a lower risk of mortality.

Therefore, a healthy lifestyle is considered to be the primary form of prevention of non-communicable diseases. Evidence indicates that ischemic heart disease and other atherosclerotic diseases arise primarily a result of individual lifestyle choices. Of the three risk factors commonly cited, cigarette smoking is clearly a consciously chosen behaviour trait; serum cholesterol level is usually related to the richness of diet, subject to genetic selection; and hypertension is associated with salt intake, weight, and stress. Additional risk factors of atherosclerosis that are commonly recognized include obesity, sedentary living (lack of exercise), and psychosocial tensions, all of which reflect cultural and behaviour characteristics (Arena et al., 2016; Basch, 1989; Loef & Walach, 2012).

Yet, this perspective and its arguments still focus on the behavioural aspects that affect the physical dimension of health and continue to neglect the other dimensions of health. According to a World Economic Forum report, health promoting programs typically put their focus on the human body (cited in Cederström & Spicer, 2015). Kline and Huff (2008) summarize that the daily choices people make with respect to diet, physical activity, sex, substance abuse and addictions, safety, and coping strategies in confronting stress are all important determinants of health. The

mental, social and spiritual dimensions step in with the question “Why do people do what they do?”, or as Arloski (2007) puts it, “why don’t people do what they need to do for themselves?”

1.4 Attitudes to health and the modern approach to health

Attitudes motivate human behaviour and are the driving force of an individual’s lifestyle. Health is a personal quality of an individual, which invites in the individual’s experience and his understanding of what health is and how it functions.

As Pachter (1994) puts it, the individual’s attitude to health is generally a conglomeration of his or her personal beliefs, attitudes, values, and behaviours, ethno cultural beliefs and values, and understanding of biomedical concepts. This personal explanatory model of health and disease influences understanding of its causality and treatment and the role of a patient and creates so called “lay theories of medicine” that guide a person’s preferences and behaviours in the health domain (W. Wang, Keh, & Bolton, 2010).

Different attitudes to health can be put on a spectrum (Pachter, 1994). On one side of the spectrum is a personal model aligned with the western biomedical model that sees the cause of illness in the natural world, whether viral or as an outcome of one’s behaviour, and provides a treatment delivered by a specifically trained physician. On the opposite side of the spectrum are models that see the cause of illness in the supernatural world, these “folk illnesses” are beyond human control. In the middle of the spectrum lie personal models in which illness may result from malfunctions of the body as a result of

factors such as diet or behaviour over which the person has some control.

The middle is a common explanation used in developed societies, where illnesses associated with health behaviours such as smoking, drinking, and lack of exercise are commonly cited as personal choices the individual makes. This category also recognizes hereditary, social, economic, and other personality factors that may play a role in illness causality and response. Within this spectrum, the individual’s locus of control determines whether the person will take responsibility for his or her own health or see it as lying outside of the person, handing it to the physician or god or destiny (Helman, 2007; Kline & Huff, 2008; Pachter, 1994; Skolnik, 2007).

Understanding the specific attitude to human health across cultural and ethnic groups becomes crucial as it influences one’s behavior and lifestyle related to health, and therefore has an impact on healthcare delivery, effectiveness of treatment and prevention, and health promoting activities (Brislin & Yoshida, 1994; Hammerschlag, 1989; Kline & Huff, 2008; Pasick, D’Onofrio, & Otero-Sabogal, 1996).

In upcoming chapters, we will develop this spectrum by looking closely at the principles of two major approaches to medicine, the modern-western and traditional-eastern medical systems. We will uncover the current trends that are bringing these two paradigms closer in order to suggest a paradigm that will serve as a grounding theory for the practical part of this research.

The modern approach to human health that is based on scientific findings and technological development is often referred to as biomedicine or Western medicine. The latter term is often used in comparison to traditional healing systems, for example in China, India or other eastern countries (Baronov, 2008; Chen et al., 2015; He et al., 2014; Qu, Liu, Zhang, & Liu, 2014; Sharma, 2012; Tu, Li, Liu, & Liu, 2011; W. Wang et al., 2010).

Qu et al. (2014) describe several principles of western medicine. Primarily, it is applied in strict accordance with experiments and measurement verifications, focuses on the concept of reductionism at a microscopic level, and emphasizes microscopic substances, such as molecules and cells. Considering western medicine, doctors (subjects) analyse problems of patients (objects) by using standard and routine methods, modern instruments, and standardized indices. Western medicine also follows a paradigm of random control experiments. In addition, Kline and Huff (2008) briefly characterize common knowledge of western medicine by the germ theory, diseases of lifestyle, medications, radiation, surgery, and other approaches to preventing and/or diagnosing and treating health problems in the general population.

These modern methods and approaches have resulted in improved public health, better nutrition, and better treatments for common diseases that have resulted in greater life expectancy. As populations age, their use of medical services increases, and the diseases they develop become more difficult and expensive to treat (Weil in Koop et al., 2002). Major health care problems such as chronic, degenerative illness, by nature

more stubborn and more costly to manage and accompanied by patient dissatisfaction, inequity of access to care, and spiraling costs, no longer seem amenable to traditional biomedical solutions (Kleinman et al., 2006).

2 AIMS, RESEARCH QUESTION

The main aim of the presented study is to keep a broader perspective on the term health, examining it through the lens of Kinanthropology. The next aim is to analyse health approaching it from the positive perspective of human flourishing.

The main research question states: “What can one do to feel better? Could the answer be to “Live healthier”?”

3 METHODS

From the point of view of methodology of investigation of these phenomena, methods of analysis, synthesis, induction and deduction were chosen and applied to the method of anchored theory in the sense of studying the concept as the main category, as well as causal and operational thinking.

4 SOLUTION TO THE PROBLEM AND A PREDICTION REGARDING THE BEHAVIOUR OF VARIABLES

4.1 Traditional approach to the health and Western-Eastern synergies and opportunities

On the opposite side of the spectrum of health lies traditional medicine, i.e. the ways of maintaining health and treating disease used by previous generations and by indigenous and other non-Western cultures. Traditional medicine, which involves natural and simple methods of healing, has been the only available

medicine in many societies for decades and even centuries. These therapies have been broadly questioned as modern medicine and scientific examination proved them to be ineffective in treating viral diseases or acute injuries (Weil in Koop et al., 2002).

In contrast to the modern approach, the traditional societies can see other causes of illness than just disease including, for example, mixing hot and cold foods, losing soul, destiny, punishment or a call for re-balancing and re-evaluating one's lifestyle. This is very distinct from western thinking (Skolnik, 2007). Basch (1989) summarizes that modern society believes in a probabilistic universe where nothing is known with absolute certainty, and thus we are committed to abide by the results of "objective" statistical tests. In contrast, traditional cultures and individuals are unable or unwilling to agree that the world is governed by the laws of probability and are restricted to the folk explanations involving purposeful intent. From his perspective, it is entirely logical to seek out the source of harm, whether it is enemies, gods, or spirits.

Closer to the centre of our graph lie the two main examples of traditional medicine, Ayurveda and traditional Chinese healing. These are specific medical systems, distinguished from Western medicine in terms of theories, clinics, and basic research. For example, traditional Chinese medicine focuses on the macroscopic homeostasis of the body and explains "what" life is, why certain illness happens, and what the patient did. This system applies the theory of Yin-Yang and the Five Elements, and considers a human as a combination of "xing" (form) and "shen" (spirit). In addition, "sizhen" (four techniques of diagnosis, i.e., inspection,

auscultation-olfaction, inquiry, and palpation) and "bagang" (eight guiding principles, i.e., yin and yang, cold and heat, exterior and interior, deficiency and excess) are applied in traditional Chinese medicine (Qu et al., 2014). By comparison, Western medicine also discusses "why" a specific process happens and how it happened, yet it explores the microscopic details of life and disease processes and uses antibiotics, roentgen and other modern technological devices and findings (Basch, 1989).

When we think of traditional medicine, "exotic" Eastern medical systems, the healing procedures of Native Americans and Central American shamans usually comes to mind. At the same time, European modern medicine stands on traditional roots. Aristotle, in the 5th century B.C., aimed to offer an explanation for health and illness in his writings and to define a model of good health in which one seeks for "nothing in excess (Stănciulescu, Diaconescu, & Diaconescu, 2015)." Hippocrates, in ancient Greece, considered health to be an internal equilibrium of the four bodily humours: blood, phlegm, black bile, and yellow bile and the disturbance of that internal equilibrium yielded disease. In this theory, factors in the environment and an individual's ways of responding to them profoundly affect health, because the balance between man and his environment determines the balance of his inner equilibrium (Breslow, 2006). Another example is Kalokagathia, the ancient ideal of "the beautiful and the good", the healthy balance of beautiful soul, beautiful body and virtuous life. Some authors explain it as a harmony between an individual and the world around (Šíp, 2008).

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These examples illustrate how in many traditional societies the overall theme of a healthy life is not to challenge nature, but to harmonize with it. In this society, people do not struggle for personal achievement; instead they function within prescribed roles as members of an integrated society (Basch, 1989). This approach was disrupted in Europe during the Middle Ages when Descartes and others, who defined the scientific revolution, proposed the concept of a duality of mind and body that resulted in a fragmented approach to interpreting human functioning that has been profound in modern medicine (Myers & Sweeney, 2008).

Various traditional approaches to health that exist today regard human beings as more than physical bodies, taking account of their mind and emotions, their spirit, and the communities in which they live (Koop et al., 2002). Traditional healing systems usually contain some philosophical system that broadens the scope of human health beyond the physical domain, towards mental as well as spiritual and social matters. Beyond the philosophical background, other common traits of traditional healing systems include: an individualized approach to patients and care (Banerjee, Debnath, & Debnath, 2015; Gupta, 2015; Liu, 2009); the importance of the state of balance (Breslow, 2006; Gokani, 2014; Jette, Vertinsky, & Ng, 2014; Limb & Hodge, 2008); and empowerment for individual lifestyle change (Herriott, 1994; Jette et al., 2014; Prajapati & Sharma, 2014). In modern terminology we could say they address topics like stress reduction, trust,

social networks, a sense of empowerment, and resilience which are also associated with the maintenance and enhancement of human health (Ewert & Voight, 2012). Therefore, traditional medicine and its approach seems to be closer to the WHO definition of health than many biomedical treatments that cure only the physical body and disease.

As previous lines suggest both modern and traditional medical systems exhibit distinct advantages and can be applied to solve problems using their own features and strong points. On this note, Hammerschlag (1989,) points out that:

“What we see as science, the traditional societies can see as magic. What we see as magic, they see as science. I don’t find this a hopeless contradiction. If we can appreciate each other’s views, we can see the whole picture more clearly. To heal ourselves or to help heal others, we need to reconnect magic and science, our right and left brains (p. 14).”

The current scientific attention given to eastern healing practices such as meditation, mindfulness practices and yoga, can be a proof of that statement. The supposedly distinct medical systems have a lot in common and can be complementary to each other in many aspects. For example, Wang (2013) suggests that the macroscopic and holistic approach of the East potentially fares well at aging and chronic and complex conditions such as obesity, the most crucial critiques of modern western medicine, together with the financial struggle with costly treatments and its insufficiency in treating lifestyle diseases (Niemi & Ståhle, 2016; Zis, Jacobs, & Shapiro, 1996). Current patients in search of better health find something in yoga class or aromatherapy

sessions that a regular physician cannot, or does not, deliver.

The mixed and non-standardized cluster of traditional methods still calls for scientific probation, as the body of scientific knowledge continues to grow and we can explain more aspects and factors of human health. To do this, we turn to alternative medicine, which doesn't aim to replace modern medicine, but to be recognized as its valuable complement.

The usual understanding of alternative medicine is "all modalities of treatment not currently taught in schools of conventional medicine." These include the formal traditional Chinese and Ayurveda systems described above, as well as homeopathy, specific interventions like hypnotherapy and other mind-body techniques, botanical medicine, nutritional medicine (encompassing the use of dietary supplements), various forms of ethno medicine, systems of body work and manipulation, and forms of energy medicine (Koop et al., 2002). These treatments have become increasingly popular in recent decades, in both developing countries and the wealthier westernized neighbourhoods of Europe and North America cities (Basch, 1989; Tu et al., 2011). In the United States, surveys show consistently that between 30 and 40 percent of people are going to alternative providers. These visits outnumber visits to primary care physicians, and the money spent on them exceeds the money spent on primary care (Koop et al., 2002).

Smith and Kelly (2006) also comment on this recent trend, where Westerners seek solace in Eastern philosophies and therapies, such as shiatsu and onsen (hot springs) in Japan, Chinese acupuncture, reflexology, tui-na and tai chi in China, Ayurveda practices in India, and traditional

Thai massage in Thailand. Such alternative health treatments are available in Western societies, but tourists are often keen to visit their place of origin and travel for health and wellness. Stănciulescu (2015) points out that these procedures are often done mechanically and without understanding of their meaning in the context of the complex healing system. A random treatment takes the client away from the source of wisdom and healing, away from the traditional idea that he or she is solely responsible for the achievement of a state of well-being by controlling the stress, and prevents a real connection with others and their authentic experiences. It becomes a feel-good practice delivered by a professional, which is ultimately an example of a "westernized" approach to the eastern practices.

The trend outlined above illustrates a paradigm shift in medicine away from disease and illness and toward an emphasis on wellness and health (Randall, 1996). In other words, we are moving closer to the centre of our illustrated spectrum of medical approaches.

In the 21st century, clinical medicine is moving toward a model of integrative and individualized health care. This development is based as on the research findings of the human genome project, as well as a new health care model that is biological-psychological-social-environmental-spiritual. It reflects the idea of patient-centred care and in many aspects corresponds with the traditional healing systems (Liu, 2009). By emphasizing prevention and lifestyle, and attending to all the factors that influence health, integrative medicine can help patients reduce their risk of disease, especially preventable disease that now causes so

much premature death and disability and accounts for such a high percentage of healthcare costs (Koop et al., 2002; Tu et al., 2011; S.-C. Wang, 2013). Unlike the traditional biomedical model, which tends to reduce patients to a disease entity and focuses on isolating and eliminating the disease, the patient-centred approach seeks to optimize functioning and wellbeing. In order to successfully achieve this goal, clinicians must include qualitative assessment methods in their diagnostic procedures and, similarly, must consider the impact of treatment on the patient as a whole being (Jamner & Stokols, 2000). This approach empowers patients by charging them with responsibility for the maintenance of health through wise lifestyle choices, and encourages them to enter into partnerships with physicians rather than into dependent roles (Koop et al., 2002).

4.2 Conceptual context of wellness

Although some authors do not distinguish between health and wellness (Thompson & Rew, 2015), others differentiate between the terms, advocating that health is a broader, more comprehensive concept (Bezner, 2015; Corbin & Pangrazi, 2001). As Myers (1992) concludes, even though the terms are often used interchangeably in research, education and practice, wellness is not synonymous with health.

Where health consists of social, spiritual, emotional and physical components, wellness is a positive state of being where these components are all functioning optimally with balance and harmony. Balance is reached when the energy forces of the body flow freely in equilibrium (Dunn, 1959; Myers, 1992;

Travis & Ryan, 2004). The dynamic notion of wellness sees it as a process of personal growth and adopting behaviours in multiple dimensions that improve functioning, rather than as an outcome (Dunn, 1959; Jonas, 2005; Travis & Callander, 1990). Where health is a state of being, wellness is the process of being or becoming that moves one along a path toward realizing their full potential (Dunn, 1961; Jonas, 2005). Being “well” means taking a conscious, integrated approach to self-improvement and functioning improvement to fully engage in life. Rather than wait for a disease state to become apparent and rely on a clinician to treat the disease, wellness is aimed toward self-reliance in achieving one’s full potential within the environment or health state within which he or she is living, rather than being a passive consumer of medical treatment (Ardell, 1977; Dunn, 1959; Jonikas et al., 2013; Kirkland, 2014; Naci & Ioannidis, 2015; Roscoe, 2009).

The wellness approach to medical care was first articulated by Dunn (1959) as a critique of the dominant biomedical model of patient care that fragments the mind, body and spirit of an individual into separate components to be serviced by distinct professional disciplines. The wellness approach is a paradigm shift away from the biomedical model that considers the mind, body and spirit to be integrated entities, emphasizing strengths and empowerment over disease and functional limitations (Breen, Green, Roarty, & Sagers, 2008; Dunn, 1959; Larson, 1996; Strout & Howard, 2015). The wellness paradigm is consistent with the World Health Organization’s definition of health and here begins the modern history of wellness:

“It was in the context of demographic changes then being brought about by the conquest of infectious disease that [Halbert Dunn] found the Constitution of the World Health Organization, which had been promulgated a decade earlier, particularly helpful. For him the WHO constitution propagated a notion of “positive health” that was in principle identical with wellness. At its root was a holistic concept of health.” (J. W. Miller, 2005a, p. 88)

Halbert Dunn (1961) initially introduced positive health as wellness in 1959, describing wellness as “not a relatively flat, uninteresting area of ‘unsickness’ but rather a fascinating and ever-changing panorama of life itself.” For him, wellness embodies the preventive aspects of what we are fighting in terms of disease and disability and social breakdown, although the enhanced physical state of health is not generally seen as its primary objective.

Wellness and a wellness approach are positive and affirming, to build upon achievements and strengths (G. Miller & Foster, 2010). This concept is aligned with Dunn’s original definition that described wellness as “an integrated method of functioning which is oriented toward maximizing the potential of which the individual is capable.” (Dunn, 1959) This person-centred approach respects an individual’s values, autonomy, motives and preferences (McMahon, O’Shea, Tapsell, & Williams, 2014; Reeve, 2006; Swarbrick, 2006) and can be seen as an approach to “whole-person” or holistic care within the medical system. As such it is also more receptive to the spiritual aspects of human life, that are for some authors at the core of wellness (Briggs et al., 2011; Grant, 2007; Ihara & Vakalahi,

2011; Limb & Hodge, 2008). This represents a shift away from orthodox religion towards a kind of transcendent spirituality, where one aims to develop beyond the self and the ego. (Smith & Kelly, 2006) Aligned with this perspective, Myers et. al (2000) defined wellness as “a way of life oriented toward optimal health and well-being, in which body, mind, and spirit are integrated by the individual to live life more fully within the human and natural community. Ideally, it is the optimum state of health and well-being that each individual is capable of achieving.” (p. 252)

More recently, the WHO defined wellness as the optimal state of health of individuals and groups realized by achieving one’s full potential and fulfilment of social roles (World Health Organisation, 2006). This articulates with the broader perspective of wellness, that goes beyond individual health to the health of the community and society that was essential in the former concepts of wellness (Dunn, 1959; Travis & Callander, 1990). Stănculescu et al. (2015) note that the wellness paradigm is not modern in its meaning, but mostly in its terminology and operationalization. This western wellness philosophy draws heavily upon Eastern and Native American understandings of health and happiness in promoting balance and harmony between the mind, body and spirit, and community and unity with all.

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However, the modern conceptual models of wellness reflect an individualistic orientation and are often operationalized with secular interventions that target an isolated problem (Limb & Hodge, 2008).

The neo-liberal philosophical foundation upon which the wellness paradigm is based places health within the control and responsibility of the individual, can be perceived as moralizing the ability to achieve health, and places the failure to achieve health as a weakness of the individual (Basas, 2014). This view of health and wellness disconnects individuals from communities; therefore, some authors point out that this individual achievement perspective may not be applicable to cultural groups who understand that the wellness of the individual is dependent upon the wellness of the family and community, or that emphasize the wellness of the family or community over the wellness of the individual (Alan & Shapiro, 2006; Boksa, Joobar, & Kirmayer, 2015; Ihara & Vakalahi, 2011; Kathy Langlois, 2008; Saint Arnault, 2009; Wilson & Hopkirk, 2014).

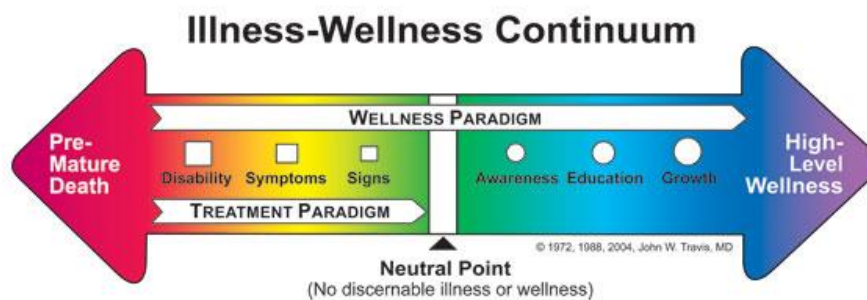
Even within individualistic cultures, individuals may still place the needs of family or community members above their own wellness, thus necessitating wellness initiatives that target the group in order to address the wellness needs of the individual (Underwood, Berry, & Haley, 2009). Halbert Dunn recognized that the individual cannot have wellness without wellness for the family and social group. His model accounted for the integration of individual, family, community, social and environmental wellness (Dunn, 1961). The similar perspective was followed by Travis, who in his work emphasized the need for connection as one of the aspects of individual, family and planetary wellness (Travis & Ryan, 2004). More recently, the Ecological model of wellness relates the wellness of the individual to that of the family, community and society (Prilleltensky, 2008). Individuals, families,

communities, and society are placed in hierarchical, concentric circles, with society at the base and individuals at the top, indicating that the wellness of the individual is dependent upon the wellness of the family, community and society.

Being “well” it means taking a conscious, integrated approach to self-improvement that improves functioning to fully engage in life, rather than wait for a disease state to become apparent and rely on a clinician to treat the disease. Instead, wellness is aimed toward self-reliance in achieving one’s full potential within the environment or health state within which he or she is living, rather than being a passive consumer of medical treatment (National Wellness Institute; Ardell, 1977; Dunn, 1958; Roscoe, 2009; Kirkland, 2014; Copeland and Jonikas, 2015). Individuals are encouraged to take responsibility for their own self-care and to embrace active lifestyle changes that promote health in the physical, social, mental, and spiritual realms (Miller, 2005). The implication of the lifestyle definition of wellness is that experiencing wellness is not dependent on being free from symptoms, illness or disease as implied by the “wellness as a state beyond absence of disease” definition. Individuals with chronic diseases or disabilities may also live a wellness lifestyle and strive toward a self-determined experience of optimal physical, mental, and social functioning (Gatchel & Kishino, 2012). Travis and Ryan (2004) illustrate this on a continuum, where the medical treatment approach takes care of persons with signs, symptoms or disabilities caused by an illness, whereas the wellness paradigm overlaps the whole spectrum and also takes care of persons who are physically healthy. It promotes a

better, joyful and satisfying life from the very point in which they are now, despite

the actual state of their physical health.



This notion of wellness has its origins in the early definitions of the word as an antonym for illness; if one is not ill, he is well (Dunn, 1961; J. W. Miller, 2005b). Illness and wellness are subjective experiences of health, where disease is an objective biological state (Basch, 1989; Gatchel & Kishino, 2012). Disease is incompatible with health as a complete state of well-being (according to the WHO definition), but it is compatible with wellness. A person suffering from a specific disease can lead a productive and satisfying life full of wellness despite disease or disability status (Bezner, 2015; Naci & Ioannidis, 2015; Roscoe, 2009; Travis & Ryan, 2004). The wellness approach allows people to find meaning in illness, drawing attention to internal imbalance and opportunities to regain balance (Briggs et al., 2011; Epstein, Senzon, & Lemberger, 2009). Moreover, freedom from disease need not be a required outcome of wellness efforts; in fact, it may not even be a reasonably attainable goal given that disease, disability, injury and death are all part of the human experience. With Thomas Jefferson we can conclude that “Without health, there is no happiness” (cited in Frank, 2011).

5 CONCLUSIONS

Wellness emerged as a new term that would broaden the focus from physical health and would integrate the body, mind and spirit of an individual within the social context in which they exist, while empowering them to take responsibility for the state of their health at any given moment. Unfortunately, the former understanding of health as absence of disease has remained, not only within the minds of the public, but also in scientific approaches to health, and most especially in the medical field.

Though wellness in its subjective and situational nature is hard to measure and describe scientifically, it offers a conceptual basis for practical applications when one is creating strategies for health promotion across all dimensions. Little is known about what affects wellness, as opposed to what causes disease. Lifestyle choices and behaviours (e.g. physical activity, meditation, and nutrition), technology, social participation and engagement, genetics, work, school, neighbourhood, and other environmental exposures, may all shape wellness (Naci & Ioannidis, 2015); however, when promoting health in all four dimensions, we cannot focus only on the

behavioural part, by promoting solely the healthy lifestyle behaviours. It is important to consider also an individual's cognitive and affective characteristics and the given context of his life, community and broader society, with its specific norms, beliefs and approaches. Melnyk (2015) argues that the term wellness should be superior to healthy lifestyle, since the latter refers to a how individual wellness manifests in an individual's life.

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