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Defining Wellness and Its Determinants

Introduction

Wellness is not an easy concept to define. The term is used in everyday language with an assumption that everyone knows what it means. Many have made attempts to define wellness. The first part of this chapter looks at wellness from a holistic perspective. It summarizes definitions and conceptualizations of wellness within the literature of the past 30 years and looks at the major comprehensive studies to identify dimensions of wellness. It is based largely on a discussion paper produced as a background document for this Atlas. This was based on an extensive review of the wellness literature, involving online database keyword searches, screening of abstracts, and assessing the relevance of articles. Over 200 journal articles, books, and websites were examined to determine how wellness was defined, and to locate research and wellness models to support the *BC Atlas of Wellness* (Miller, 2007). The second section of the chapter focuses on the importance of the determinants of population health and wellness. This approach to considering factors that are important to understanding health and wellness status has become very prominent over the past 15 years or so, and is an important way of considering health and wellness from a perspective that is more community- or population-based. These two approaches to assessing the dimensions of health and wellness provide a basis for understanding the reasons for the inclusion of many of the mapped indicators that appear in the later sections of this Atlas.

Wellness from a Holistic Perspective

Holism emerged from the approach used by scientists to study complex phenomena such as organisms and ecosystems (Richards and Bergin, 1997), and from a shift in society toward a worldview that is more holistic and relational (Larson, 1999). The term wellness appeared as part of a parallel transformation in the definition of health toward a more holistic perspective that is interrelational, positive in nature, and focuses on the examination of healthy human functioning (Westgate, 1996). Previous definitions held the view that health was concerned with illness and the body was considered in terms of isolated physiological systems (McSherry and Draper, 1998). The holistic perspective completely transformed this notion of health and the wellness movement was perhaps the catalyst that began this transformation.

The wellness movement began after the end of World War II largely because society's health needs changed. Advances in medicines and technology meant vaccines and antibiotics reduced the threat of infectious diseases, which until that time had been the leading cause of death (Seaward, 1997, 2002). Instead, chronic and lifestyle illnesses (e.g., heart disease, diabetes, cancer), associated with numerous stressors in life and the workplace, became the primary health concern. This introduced an expanded concept of health as encompassing all aspects of the person (mind, body, spirit) (Donatelle, Snow, and Wilcox, 1999), a concept that had been lost by western but not by indigenous societies (Elliott and Foster, 1995).

This expanded view of health allowed the development of preventive health measures and a focus on optimal health as practitioners address the whole person, and consider the causes of lifestyle illnesses rather than just their symptoms. But the language used to describe health and, similarly, wellness has become more complex and confusing. Current literature reveals additional terms corresponding and interrelating to the notion of wellness, namely well-being, quality of life, life

satisfaction, happiness, and general satisfaction, the latter being a term similarly understood by many cultures and used in international studies.

Conceptualizing Wellness

Several authors have attempted to define and filter out major concepts around the meaning of wellness (Table 1). It has been argued that wellness is subjective, inherently has a value judgement about what it is and what it is not, and that an accurate definition and measurement of the construct is difficult (Kelly, 2000; Sarason, 2000). Therefore, authors have conceptualized wellness on a continuum and not as an end state (Clark, 1996; Dunn, 1977; Jonas, 2005; Lafferty, 1979; Lorion, 2000; Myers, Sweeney, and Witmer, 2005; Sackney, Noonan, and Miller, 2000; Sarason, 2000).

Larson (1999, p. 123) states that the World Health Organization (WHO) was the first to introduce a holistic definition of health as "a state of complete physical, mental, and social well-being and not merely the absence of disease and infirmity" (1948), and many subsequent conceptualizations of wellness include this central concept. The President's Council on Physical Fitness and Sport for the US has been very involved in defining wellness, and Oliphant (2001) explains that the suggestion by WHO (1967) that health has a positive component led to the now widely used term "wellness."

Dunn (1977) emphasized wellness as a positive state, one that is beyond simply non-sickness, elaborating on the WHO definition by emphasizing the varying degrees of wellness and its interrelated, ever-changing aspects. He detailed the interconnected nature of wellness of the mind, body, and environment, which exists as a dynamic equilibrium as one tries to balance between each. Dunn (1977) conceptualized the dimensions of wellness fluctuating as people make active choices moving toward or away from their maximum potential.

Egbert (1980) summarized the central areas of wellness as being a combination of having a strong sense of identity, a reality-oriented perspective, a clear purpose in life, the recognition of a unifying force in one's life, the ability to manage one's affairs creatively and maintain a hopeful view, and the capability of inspired, open relationships. WHO (1986, p. 2) further clarified the definition, noting that to reach a state of health "an individual or a group must be able to realize aspirations and satisfy needs, and to change or cope with the environment," while Bouchard and colleagues (1994, p. 23) suggest that "positive health pertains to the capacity to enjoy life and withstand challenges." Lastly, Witmer and Sweeney (1992) defined wellness in terms of life tasks that include self-regulation, work, friendship, spirituality, and love.

Many researchers have explored and defined the various components, or interrelated areas, that comprise wellness. Depken (1994) noted that most college health textbooks describe wellness as encompassing physical, psychological/emotional, social, intellectual, and spiritual dimensions. Lafferty (1979) defined wellness as a balanced amalgamation of these five factors and purposeful direction within the environment. Similarly, Greenberg (1985) defined wellness as the integration of the five dimensions and high-level wellness as the balance among them, but utilized the term mental

Table 1: Dimensions of wellness

	Physical	Emotional Psychological	Social	Intellectual	Spiritual	Occupational	Environmental
Adams et al., 1997	x	x	x	x	x	x	
Anspaugh et al., 2004	x	x	x	x	x	x	x
Crose et al., 1992	x	x	x	x	x	x	
Durlak, 2000	x		x	x			
Hales, 2005	x	x	x	x	x	x	x
Helliwell, 2005	x	x	x		x	x	x
Hettler, 1980	x	x	x	x	x		
Leafgren, 1990	x	x	x	x	x	x	
Renger et al., 2000	x	x	x	x	x		x
Ryan and Deci, 2001	x	x					x
Ryff and Singer, 2006	x	x	x				x

wellness in place of intellectual wellness. Hettler (1980) included an occupational dimension and stressed wellness as the process of becoming aware of wellness and actively making choices towards optimal living.

Towards the end of the last millennium, Adams, Benzer, and Steinhardt (1997) conceptualized wellness from a systems approach, where all subsystems have their own elements and are an essential part of the larger system. The authors described wellness as health-focused, and emphasized the importance of including multiple factors such as cultural, social, and environmental influences from a systems perspective. They included the additional dimension of psychological wellness relating to positive outcomes in response to life's circumstances.

An emphasis on an "integrated and positive spiral of mind-body influences" has been suggested by Ryff and Singer (1998, p. 14). They contend that "zestful engagement in living and loving…remains primarily the purview of philosophy." They indicate that perceptions, beliefs, and cognitions are clearly linked to their physiological responses to the world. They state that well-being obviously includes good mental health, but emotional health does not have to be linked to physiological substrates to be beneficial. The two authors offer a reasonable list of contributing factors gathered from a range of sources, and these health constituents include social support, dispositional optimism, relationship quality, leading a life of purpose, achieving mastery, and possessing positive self regard.

Renger and co-authors (2000) defined wellness as consisting of physical, emotional, social, intellectual, and spiritual dimensions, and added environmental wellness to recognize the important impact of one's surroundings, a concept also discussed by Sackney, Noonan, and Miller (2000). Renger and co-workers stressed the importance of knowledge, attitude, perception, behaviour, and skill in each of several wellness areas, as well as integration and balance.

Adams (2003) has defined four main principles of wellness: 1) wellness is multi-dimensional; 2) wellness research and practice should be oriented toward identifying causes of wellness rather than causes of illness; 3) wellness is about balance; and 4) wellness is relative, subjective, and perceptual. Schuster and colleagues (2004, p. 351) state there is general consensus that definitions of health include multiple domains, among them physical, psychological (mental, intellectual, emotional), social, and spiritual. Wellness is described as "a higher order construct integrating these domains, drawing on individual self-perception."

Myers, Sweeney, and Wittmer (2005, p. 252) define wellness as being "a way of life oriented toward optimal health and well-being in which the body, mind, and spirit are integrated by the individual to live more fully within the human and natural community." The notion that wellness is more a psychological than a physical state has been a focus of several researchers. Anspaugh and co-authors (2004) and Hales (2005) refer to seven dimensions of wellness: physical, emotional, social, intellectual, spiritual, environmental, and occupational.

Jonas (2005, p. 2) elaborates on the difference between health and wellness, saying that health is a state of being, whereas wellness is a process of being. Wellness is defined as:

> *a way of life and living in which one is always exploring, searching, finding new questions and discovering new answers, along the three primary dimensions of living: the physical, the mental, and the social; a way of life designed to enable each of us to achieve, in each of the dimensions, our maximum potential that is realistically and rationally feasible for us at any given time in our lives.*

Rickhi and Aung (2006) believe creating wellness can mean focusing on practices that benefit one or all of the three dimensions—body, mind, and spirit. Physical wellness includes drinking water, healthy eating, healthful touch such as massage, and physical activity. Mental and spiritual wellness requires mind/body-based stress reduction programs, adapting the body to nature and being aware of the senses.

Recently, Smith and Kelly (2006) have suggested that lack of community may be spurring wellness tourists to seek a sense of community within a holistic centre, a yoga retreat, at a New Age festival, or on a pilgrimage.

Dimensions of Wellness

The above summary of key researchers indicates that there are several main dimensions to defining wellness: physical; psychological/emotional; social; intellectual; spiritual; occupational; and environmental. These are briefly discussed further, below.

Physical Wellness

In general, physical wellness includes physical activity, nutrition, and self-care, and involves preventative and proactive actions that take care of one's physical body. Cooper (1968, 1970, 1975, 1977) studied the relationship

of exercise to health and longevity, particularly how exercise reduced the risk of heart disease. His findings revolutionized the fitness industry's understanding of health and wellness and advanced the understanding of the relationship between living habits and health.

Physical wellness encompasses maintenance of cardiovascular fitness, flexibility, and strength. Actions to improve physical wellness include maintaining a healthy diet and becoming in tune with how the body responds to various events, stress, and feelings by monitoring internal and external physical signs. This includes seeking medical care when appropriate, and taking action to prevent and avoid harmful behaviours (e.g., tobacco use and excess alcohol consumption) and detect illnesses (Hettler, 1980; Renger et al., 2000; Leafgren, 1990). Crose and co-workers (1992) included medical history and medications, body awareness, and image. Durlak (2000) and Anspaugh and colleagues (2004) detailed physical wellness to include physical indices (muscle tone, cholesterol level, blood pressure) and behaviours (eating habits, exercise levels). Problems in physical wellness included physical injuries and disabilities, and sexually transmitted diseases.

Helliwell (2005) found optimism about good health resulted in higher wellness scores. He also found that age was of great interest because one might assume happiness decreases with age, whereas in fact 18- to 24-year-olds and 55- to 64-year-olds are equally the happiest of all age groups, with 35- to 44-year-olds being the least happy. Even 65 year olds and above were a lot happier than this 35- to 44-year-old cohort.

Ryff and Singer (2006) found that avoiding negative behaviours such as smoking and inactive living, as well as body type, affects physical wellness, with benefits including better autoimmune functioning. Ryan and Deci (2001) note that physical wellness, however, does not always correlate to one's sense of well-being: a person can be ill and have a positive state of mind, while a physically healthy person can experience a poor sense of well-being.

Psychological/Emotional Wellness

Relatively few discuss psychological wellness, but there is some agreement that it is one's sense of expectation that positive outcomes result from the events and experiences of life. Emotional wellness is conceptualized as awareness and control of feelings, as well as a realistic, positive, and developmental view of the self, conflict, and life circumstances, coping with stress, and the maintenance of fulfilling relationships with others (Adams, Bezner, and Steinhardt, 1997; Leafgren, 1990). Hettler (1980) considered emotional wellness to be a continual process that included an awareness and management of feelings, and a positive view of self, the world, and relationships.

Renger and co-workers (2000) defined emotional wellness as related to one's level of depression, anxiety, well-being, self-control, and optimism. Emotional wellness includes experiencing satisfaction, curiosity, and enjoyment in life, as well as having a positive anticipation of the future, or optimistic outlook. Ryan and Deci (2001) describe the self-determination theory (SDT) as another perspective that fits within the concept of self-realization as a central definitional aspect of wellness, and that SDT specifies both what it means to actualize the self and how this can be accomplished. This involves the fulfillment of basic psychological needs: autonomy, competence, and relatedness resulting in psychological growth (e.g., intrinsic motivation); integrity (e.g., internalization and assimilation of cultural practices); and well-being (e.g., life satisfaction and psychological health); as well as the experiences of vitality (Ryan and Frederick, 1997) and self-congruence (Sheldon and Elliot, 1999). Ryff and Singer (2006) indicate that quality ties to others are central to optimal living and are connected to psychological factors. Self-actualizers have strong feelings of empathy and affection for all human beings and have a greater capacity for love and deep friendships and more complete self-identification with others than non-actualizers. This, they indicate, develops with maturity.

Personality is one of the strongest indicators of well-being (Diener, Eunkook, Suh, Lucas, and Smith, 1999), with genes accounting for 40% of positive emotionality and 55% of negative emotionality. Features of the environment, one's behaviour, and one's personality may mutually influence each other and affect subjective well-being. According to Harrington and Loffredo (2001), personality aspects of individuals may affect life satisfaction, citing people who are more self-conscious and introverted scoring lower levels of life satisfaction than extroverts. The discussion of extroversion demonstrates varying results, with Diener and colleagues (1999) suggesting that social involvement is required by the demands of society and extroverts are more comfortable in social situations. Pavot and co-authors (1990) found that extroverts were happier in all situations, whether social or in isolation. Diener and co-workers (1999) proposed an intriguing idea that the

characteristics of extroverts are actually an outcome of higher levels of positive affect. DeNeve and Cooper (1998) quote Wilson (1967) as stating that a happy individual is one who is extroverted, optimistic, and worry-free.

Longitudinal studies (Sheldon and Kasser, 1998, p. 1322) suggest that, "whereas progress toward intrinsic goals enhances wellness, progress toward extrinsic goals such as money either does not enhance wellness or does so to a lesser extent." Ryan and Deci (2001, p. 154) summarize reviews of the literature on the topic of wealth and happiness by stating that: "The relation of wealth to well-being is at best a low positive one, although it is clear that material supports can enhance access to resources that are important for happiness and self-realization. There appear to be many risks to poverty but few benefits to wealth when it comes to well-being." In addition, studies show that valuing wealth and material goods above intrinsic self-realizational goals adversely affects psychological wellness.

Hales (2005) includes trust, self-esteem, self-acceptance, self-confidence, self-control, and the ability to bounce back from setbacks and failures as important wellness attributes. Maintaining emotional wellness requires monitoring and exploring thoughts or feelings, identifying obstacles to emotional well-being, and finding solutions to emotional problems, if necessary with the help of a therapist.

Social Wellness

Social wellness encompasses the degree and quality of interactions with others, the community, and nature. It includes the extent to which a person works toward supporting the community and environment in everyday actions, such as volunteer work (Hettler, 1980). Included in the definition of social wellness is getting along with others and being comfortable and willing to express one's feelings, needs, and opinions; supportive, fulfilling relationships (including sexual relations), and intimacy; and interaction with the social environment and contribution to one's community (Renger et al., 2000). Leafgren (1990) and Crose and colleagues (1992) confirm the importance of significant relationships and the quality and extent of one's social network. Crose and colleagues (1992) examine the nature of relational styles and patterns, focusing on one's attitude toward relationships and seeking help from others as key to social wellness. Ryff and Singer (2006) cite epidemiological studies stating that mortality is significantly lower among persons who are more socially integrated. Features of social support consist of the size or density of one's social network and frequency of contact with relatives and friends.

Durlak (2000) includes peer acceptance, attachments/bonds with others, and social skills (communication, assertiveness, conflict resolution) as fundamental to social wellness. Helliwell (2005) found that married people are happier, and separated individuals are the least happy, even less so than those who are divorced. Anspaugh and colleagues (2004) also include the ability to maintain intimacy, to accept others different from yourself, and to cultivate a support network of caring friends and/or family members.

Intellectual Wellness

Intellectual wellness is the degree to which one engages in creative and stimulating activities, as well as the use of resources to expand knowledge and focus on the acquisition, development, application, and articulation of critical thinking. It represents a commitment to life-long learning, an effort to share knowledge with others, and development of skills and abilities to achieve a more satisfying life (Hettler, 1980). The perception of being energized by an optimal amount of intellectually stimulating activity that involves critical reasoning is also important (Adams et al., 1997). Hales (2005) concurs and includes having a sense of humour as important.

Awareness of cultural events is viewed by numerous authors as central to intellectual wellness (Crose, Nicholas, Gobble, and Frank, 1992; Leafgren, 1990; Renger et al., 2000). Renger and co-authors (2000) also defined intellectual wellness as one's orientation and attitude toward personal growth, education, achievement, and creativity. This includes attending cultural events and seeking out opportunities to gain and share knowledge, particularly knowledge of current local and world events.

In addition to attending cultural events, Leafgren (1990) cites that stimulation can come from reading, studying, travelling, and exposure to media. Crose and colleagues (1992) defined intellectual wellness as one's education and learning history, mental status, cognitive style and flexibility, and attitude toward learning. Durlak (2000) includes the development of talents and abilities, learning how to learn, and higher order thinking skills in intellectual wellness. Furthermore, he defined the problem areas as underachievement, test anxiety, and school dropouts.

Spiritual Wellness

Spiritual wellness is possibly the most developed and discussed topic in the wellness literature (Banks, 1980; Hatch, Burg, Naberhaus, and Hellmich, 1998; Ingersoll, 1994; Pargament, 1999). Spirituality is not synonymous with religion (Adams et al., 1997). Rather, religiosity and spirituality are overlapping but distinct concepts (Westgate, 1996). Spirituality can be considered to be the broader concepts of beliefs and values, whereas religiosity can be thought of as behaviours and the means of implementing one's spirituality (Westgate, 1996; Hatch et al., 1998), although Pargament (1999) has challenged this viewpoint and argued that religiosity is the broader concept.

Hettler (1980) and others (Adams et al., 1997; Renger et al., 2000) defined spiritual wellness as the process of seeking meaning and purpose in existence. It includes the appreciation of the depth and expanse of life and the universe, questioning the meaning and purpose in life, as well as recognizing, accepting, and tolerating the complex nature of the world and accepting that the universe cannot be completely understood. Hettler (1980) adds that spiritual wellness is focused on harmony with the self, and with others and the universe, and the search for a universal value system. This value system includes the formation of a worldview that gives unity, purpose, and goals to thoughts and actions.

Appyling an adaptation of the Delphi Technique to define spiritual wellness, Banks (1980) cited the following key elements: gives meaning or purpose to life, principles or ethics to live by, sense of selflessness, and feeling for others. Other important elements include: a commitment to God or ultimate being, perception of what it is that makes the universe operate as it does, recognition of powers beyond the natural and rational, a matter of faith in the unknown, involving a survival issue, and finally a pleasure-producing quality of humans.

Ingersoll (1994) initially defined spiritual wellness in terms of seven integrated dimensions that operate synergistically, but later proposed the following 10 dimensions: conception of the absolute or divine; meaning (life meaning, purpose, and sense of peace); connectedness (with people, higher power, community, and environment); mystery (how one deals with ambiguity, the unexplained, and uncertainty); sense of freedom (play, seeing the world as safe, willingness to commit); experience/ritual/practice; forgiveness; hope; knowledge/learning; and present centredness.

Westgate (1996) defined spiritual wellness in terms of holistic dimensions, proposing four spiritual wellness dimensions: meaning in life, intrinsic values, transcendence, and spiritual community. The meaning in life dimension was described as an innate human need where purpose and life satisfaction provide hope. Intrinsic values were defined as the basis of human behaviour and the principles that people live by. Transcendence signifies a relationship with a higher force and the universe, recognition of the sacredness of life, and motivation by truth, beauty, and unity. Lastly, the fourth dimension of spiritual community was defined as giving and sharing with others, shared values, myths and symbols, and the experience of community and mutual support through gathering, singing, praying, and chanting. To some extent, Hales (2005) reflects a similar view of spiritual wellness.

As noted earlier, Helliwell (2005) found age a factor in well-being, with 18- to 24-year-olds and 55 and older equally happiest of all ages. There has been some debate as to whether the higher value in the older age group is related to faith, since those who believe God is important in their lives are happier than those who don't.

Occupational Wellness

Hettler (1980) and Anspaugh and colleagues (2004) defined occupational wellness as the level of satisfaction and enrichment gained by one's work and the extent one's occupation allows for the expression of values. Furthermore, occupational wellness included the contribution of one's unique skills and talents to the community in rewarding, meaningful ways through paid and unpaid work. Lastly, occupational wellness incorporated the balance between occupational and other commitments.

Leafgren (1990) stated that occupational wellness is one's attitude about work and the amount of personal satisfaction and enrichment gained from work, while Crose and co-workers (1992) included work history, patterns and balance between vocational and leisure activities, and vocational goals. Helliwell (2005) found large reductions in well-being from being unemployed.

Environmental Wellness

In their definition of environmental wellness, Renger and co-authors (2000) include the balance between home and work life, as well as the individual's relationship with nature and community resources (i.e., involvement in

a recycling or community clean-up effort). Ryan and Deci (2001) found cultural differences when looking at wellness across 61 nations, suggesting that the cultural environment is an important factor. Anspaugh and colleagues (2004) and Hales (2005) further express concerns such as safety of food and water supply, infectious diseases, violence in society, ultraviolet radiation, air and water pollution, and second-hand tobacco smoke.

Ryff and Singer (2006) describe environmental mastery as a dimension of wellness and state that, to make the most of our lives and our world, we need to advance the science of interpersonal flourishing (p. 41).

Studying political and government structures, Helliwell (2005, p. 4) looks at the social capital of environments from a global perspective and proposes that:

> *Analysis of well-being (wellness) data provides means for combining income, employment, government effectiveness, family structure and social relations together in ways that permit the external effects of institutions and policies to be assessed.*

An international study of about 50 different countries was conducted by Helliwell (2005) utilizing data from three waves of the World Values survey (Annas, 1993). Increased income inequality is associated with lower rates of economic growth (Persson and Tabellini, 1994) and worse health. Individuals attaching high subjective values to financial success have lower values for subjective well-being, even when their financial aspirations are met (Kasser and Ryan, 1993, 1996). Higher levels of subjective well-being occur not in the richest countries, but in those where social and political institutions are effective, mutual trust is high, and corruption is low.

Summary of Wellness Definitions and Dimensions

In summarizing the various conceptualizations of wellness, many of the models and definitions are based upon similar core elements. First, most authors incorporated the idea that wellness is not just absence of illness, as first outlined by the WHO wellness definition. Second, wellness is described in terms of various factors that interact in a complex, integrated, and synergistic fashion, and the dynamic interaction of the dimensions causes the sum of the dimensions to be greater than the whole. Each dimension is integral to the whole and no one dimension operates independently. The wellness approach is holistic within the person and with the environment. Third, many authors outlined the necessity of balance or dynamic equilibrium among dimensions. Fourth, several models define wellness as the movement toward higher levels of wellness or optimal functioning and assert that wellness is, therefore, partially dependent on self-responsibility and individual motivation. Finally, wellness is viewed on a continuum, not as an end state.

Several key dimensions of wellness have emerged. Physical wellness is the active and continuous effort to maintain the optimum level of physical activity and focus on nutrition, and includes self-care and healthy lifestyle choices (e.g., use of medical services, preventative health measures, abstinence from drugs, tobacco, and excessive alcohol use, safe sex practices).

Emotional wellness includes one's attitudes and beliefs toward self and life. Definitions include a positive and realistic self-concept, identity, and degree of self-esteem, and the awareness and constructive handling of feelings. It might also include the core elements of self-view and awareness of one's actions, feelings, relationships and their management, the realistic assessment of one's limitations, and a developmental focus. It is the ability to act autonomously, cope with stress, as well as to have a positive attitude about life, oneself, and the future.

Social wellness is broad in scope because it includes the interaction of the individual with others, the community, and nature. It includes the interaction (quality and extent) with, and support of, others, the community, and the social and natural environment. Besides the interaction of the individual, society, and nature, social wellness includes the motivation, action, intent, and perception of interactions. Social wellness is comprised of the skills and comfort level one is able to express in the context of interacting with others, the community, and nature. In sum, social wellness is the movement toward balance, and integration of the interaction between the individual, society, and nature.

Intellectual wellness is the perception of, and motivation for, one's optimal level of stimulating intellectual activity by the continual acquisition, use, sharing, and application of knowledge in a creative and critical fashion. This is for both personal growth of the individual and the betterment of society.

The key aspects of spiritual wellness seem to be purpose and meaning in life; the self in relation to others, the community, nature, the universe, and some higher power; shared community and experience; and the

creation of personal values and beliefs. In summary, spiritual wellness is the innate and continual process of finding meaning and purpose in life, while accepting and transcending one's place in the complex and interrelated universe. Spiritual wellness is a shared connection or community with others, nature, the universe, and a higher power.

Occupational wellness is the extent to which one can express values and gain personal satisfaction and enrichment from paid and non-paid work; one's attitude toward work and ability to balance several roles; and the ways in which one can use one's skills and abilities to contribute to the community.

Finally, environmental wellness has a broad dimension that considers the nature of an individual's reciprocal interaction with the environment on a global level (e.g., balance, impact, control). The environment includes home, work, community, and nature.

Measuring Wellness

While there is extensive literature on the definition of wellness, there are relatively few empirical explorations of the structure of wellness. Several authors have commented on the difficulty of capturing the dynamic nature of wellness and the inadequacy of the existing measures (Adams et al., 1997; Renger et al., 2000). However, several techniques have been developed to measure wellness at an individual level. These include the Life Assessment Questionnaire (LAQ) (National Wellness Institute, 1983), developed to measure the six wellness dimensions outlined by Hettler (1980), and a modification called TestWell (Owen, 1999); the Perceived Wellness Survey (PWS) (Adams et al., 1997); the Optimal Living Profile (OLP) (Renger et al., 2000); and a Wellness Inventory (WI), developed by Travis (1981), to mention a few.

There are also several scales developed to assess spiritual wellness and well-being. These include: the Spiritual Well-Being Scale (SWBS) by Paloutzian and Ellison (1982); the Spiritual Involvement and Beliefs Scale (SIBS) (Hatch et al., 1998); the Duke Religion Index (DUREL) (Koenig, Parkerson, and Meador, 1997); the Intrinsic Religious Motivation Scale (Hoge, 1972); the Spiritual Well-Being Questionnaire (SWBQ) (Moberg, 1984); and the Expressions of Spirituality Inventory (ESI) (MacDonald, 2000).

Other researchers have conducted large-scale studies using a variety of wellness-related instruments. Mookerjee and Beron (2005) examined the influence of gender and religion on levels of happiness in 60 industrialized and developing nations using two sources of information: 1) The World Database of Happiness (Veerhoven, 2001); and 2) quality of life measuring tools including the Human Development Index, the Gastil Index of Civil Liberty, the Index of Economic Freedom, the Gini Coefficient of Income Inequality, and the Corruption Perception Index.

The urban planning field is evaluated through a set of visions rather than empirically supported theories, since consumers find it difficult to imagine what plans will look like and usually shy away from innovative ideas. Van Kamp and co-authors (2003) describe a review of urban planning visions by Smith and colleagues (1997) in terms of quality and need principles. Important elements include livability, character, connection, mobility, personal freedom, and diversity. On the basis of this physical form, criteria were developed with respect to community quality (i.e., open space areas, outdoor amenities, and 'walkability'). Van Kamp and co-authors (2003) found a need for the development of a conceptual framework that evaluates physical, spatial, and social indicators of well-being in terms of urban environmental quality, livability, sustainability, and quality of life. Both environmental quality and quality of life relate to the person, the environment, and the relationship between the two. Three approaches are used: 1) the economical; 2) the sociological (normative); and 3) the psychological (subjective). Van Kamp found authors whose studies report meaningful relationships between crowding and behaviour, housing quality and functioning of children, and the amount of green in the neighbourhood and coping behaviour (Evans, Saegert, and Harris, 2001; Moser and Corroyer, 2001; Kuo, 2001).

Ardell and Jonas (2005) have developed the Wellness Process for Healthy Living (WPHL), which is a tool for implementing the wellness concept. The five steps of the WPHL are: 1) assessment—both self-assessment and assessment by health practitioners; 2) defining success; 3) goal setting; 4) establishing priorities; and 5) mobilizing motivation. These steps provide a single common mental pathway for preparing to successfully make health-promoting behaviour change. It is necessary to be at a point of wanting to make a change before change can be made. A variety of tools can be used to measure Quality of Life (QOL), subjective well-being, and wellness. Skevington and co-workers (2004) analysed the WHOQOL-BREF, a 26-item version of the WHOQOL-100 assessment, as a valid assessment tool. This tool came from 10 years of development research on QOL and was tested in 24 countries and available

in most of the world's major languages. Sick and well respondents were sampled and the self-assessment completed, as well as socio-demographic and health status questions.

Of interest within Canada, Ekos Research Associates (2006) are devising the Canadian Index of Well-being (CIW), which will be used to account for changes in Canadian human, social, economic, and natural wealth by capturing the full range of factors that affect Canadians' well-being. The CIW encompasses seven domains that are at different stages of development, including: Living Standards, Healthy Populations, Time Allocation, Educated Populace, Ecosystem Health, Community Vitality, and Good Governance (Civic Engagement). The Atkinson Charitable Foundation, with the support of the United Way of Canada and their local agencies, as well as CIW project partners at local and national levels, consulted to find out if these seven domains capture what really matters to Canadians. The participants described the CIW as "an excellent and timely idea and a needed alternative to traditional economically based ways of measuring progress" (Ekos Research Associates 2006, p. 3).

Determinants of Health and Wellness

The influence of social factors on health outcomes has been observed since vital statistics were routinely collected in Britain more than 150 years ago. At that time, average age at death was demonstrated to be systematically associated both with occupation (unskilled labourers had a much lower average age at death than skilled labourers, whose average, in turn, was lower than the administrative occupations) and region (with counties in the north of England having a lower average age at death than those in the south) in a socially graded fashion. Interestingly, these patterns persist in England today, although occupational classifications have changed dramatically since then (Gregory, Dorling, and Southall, 2001).

In 1977, the government of the United Kingdom appointed an expert group, chaired by Sir Douglas Black, to examine the distribution of health outcomes in the UK after nearly 40 years of the National Health Service (NHS). The Black Report (Townsend and Davidson, 1982) analysed health outcomes by occupational classification for males and females across the full spectrum of age groups of 5 and 10 year intervals across the life span. Mortality (death), morbidity (chronic and short-term illnesses), and activity limitation (physical consequences of poor health) were measured for general and disease-specific causes. The report found that relative differences in health outcomes by occupation had actually increased over the nearly 40 years of public health care, and reflected a social gradient. The Report offered four possible explanations for the observed patterns: reverse causality (people who are sicker or more likely to die are less able to acquire the skills needed for higher occupational status jobs); artifact (the size of occupational groups have changed, leaving behind the most difficult cases); lifestyle (lower occupational groups make poorer health choices); and social structural and material factors (groups are systematically exposed to greater hazards in the environment—higher risk, fewer choices, and fewer resources—and the cumulative effect of these combined factors causes premature 'weathering' or wearing-out of the body). The Report gave greatest weight to the last explanation, but acknowledged that lifestyle or personal health practices were also involved. It found little evidence to support reverse causality or artifact explanations. Though all groups had experienced improvements in health outcomes, rates of improvement experienced by the higher status occupational groups (those associated with higher incomes and greater prestige) were faster than those experienced by lower status groups, so relative differences increased.

The Black Report stimulated several questions about the role of social circumstance in shaping health and wellness outcomes that galvanized international research and policy interest. Since the release of the Report, health and wellness outcomes have been observed to follow a social gradient practically everywhere the distribution of outcomes from a population health perspective has been studied. Several explanations have been offered to account for observed gradients, including materialist, psycho-social, and eco-social perspectives. While there are subtle differences between these explanations, they all have a great deal in common. Most pronounced is the shared view that our bodies respond to environmental influences, especially those emanating from our social relationships, although obviously exposure to non-social environmental factors such as UV radiation, particulate matter, noxious gases, or toxic substances also affect us. The combined influences of our material (i.e., money and the things money buys) and non-material (our abilities to problem solve, communicate our needs, and negotiate with others, often associated with education) resources appear to profoundly influence our health and wellness outcomes through various direct and indirect pathways.

The interplay of our social selves (how we imagine ourselves and our place in the world—our identity) and our biological selves (genetic factors and how our bodies function as biological systems) condition how we feel, how our bodies operate, and, ultimately, shape our health and wellness experiences. We use various markers of this complex interaction, such as income, education, or occupation, to group people into categories of social similarity and observe the aggregated impact of these processes at the population level.

Several so-called 'determinants of health' have been identified. The Public Health Agency of Canada (PHAC) identifies 11 health determinants: income and social status, social support networks, education, employment and working conditions, social environments, geography, physical environments, healthy child development, health services, gender, and culture (Public Health Agency of Canada, 2006). Participants in a Canadian conference entitled *Social Determinants of Health Across the Life-span*, held at York University in 2002, identified a similar list of social determinants of health, including income and its distribution, early life, Aboriginal status, education, employment and working conditions, food security, health care services, housing, the social safety net, social exclusion, and unemployment and employment security (Raphael, 2004). Note the subtle but important differences between the two lists. Housing, food security, distribution of income, the social safety net, social exclusion, and Aboriginal status are issues not explicitly identified (though may be implied) in the PHAC list, while gender, culture, and geography (including social and physical environments) are not explicitly identified in the list developed through the York conference. In part, the differences between the lists reflect the subtle differences embodied by the different theoretical perspectives identified above. They also reflect differences in the way language is used and concepts are treated by government-based agencies and academic/advocacy communities.

Health, Wellness, and Place

Empirical and theoretical understanding of how the interplay between daily life circumstances and human biology influences health and wellness outcomes at the population level is a central concern for makers, implementers, and researchers of social policy. This concern has, in turn, stimulated an interest in the relationship between health and wellness and place. Several researchers have examined how the socio-spatial structure of cities (or land use, property ownership, density, proximity to services, etc.) is bound up in the empirical distribution of health and wellness outcomes across socio-economic groups and reflected in small area differences in health status (see Berkman and Kawachi, 2000; Kawachi and Berkman, 2003; Dunn and Hayes, 2000; Ross et al., 2004; Oliver and Hayes, 2007). Others have attempted to assess the quality of social relationships through surveys examining feelings of safety and security, the degree of social cohesion among neighbours, participation in community organizations and civil life, and the opportunity structures available within specific locations (e.g., to purchase food, access to cultural and recreational activities, public transportation modes, etc.) (Macintyre, Ellaway, and Cummins, 2002; Oliver and Hayes, 2005).

Research focusing on the relationship between health and place has frequently (but not always) demonstrated an effect of place on health over and above the effects arising from strictly individual factors (Diez-Roux, 1998; Pickett and Pearl, 2001). That is, research indicates that the quality of the environments of everyday life does influence health outcomes, such that persons of the same income or educational attainment or occupational status may experience health and wellness outcomes that are better or worse than expected, based on the attributes of their surrounding environment. Of course, this result is hardly surprising given that all living things must constantly adapt to their environments. Yet, focusing on the specific qualities of the places we live, and understanding how these qualities influence human health outcomes draws attention to the often-overlooked issues associated with community design, or where poverty and disadvantage are concentrated. It takes our understanding of these issues and spatializes them—puts them into the landscape and into everyday life rather than leaving them in highly abstract and placeless domains of tables or figures in research reports.

Another consequence of focusing attention on how health and wellness outcomes are distributed across space (and within specific places) is that it reinforces the fact that our ability to maintain our well-being is shaped by influences of everyday life, and to understand these requires a life-course perspective. When the real world distribution of health and wellness outcomes is considered, it draws attention to issues of housing, nutritious food availability and security, recreational opportunities, and the quality of interpersonal relationships. These issues get far less attention in discussions about health, wellness, and well-being than they should according to research evidence.

The public seems obsessed with issues of health care—or so it would appear if news coverage is anything to go by. Analysis of coverage of health-related stories in both English- and French-language newspapers found that two-thirds of all stories focus on issues of health care and that only about 5% concern all topics associated with the social determinants (Hayes et al., 2007). A survey conducted by the Canadian Institute for Health Information (CIHI) discovered that two of every three Canadian adults do not immediately understand or identify social determinants of health (Canadian Institute for Health Information, 2005a). Astonishingly, these findings come about 30 years after the release of the federal government white paper entitled *A New Perspective on the Health of Canadians* (Lalonde, 1974). That report, which received world-wide acclaim, gave rise to health promotion in Canada. It argued that health (and wellness) does not equal health care, and that a focus on other factors outside the health sector was required. About 40% of our public resources are invested in health care. If support for health-enhancing policies relating to the provision of child care, housing, employment, recreation and culture, and community design is to be obtained by politicians and policymakers from the general public, a greater appreciation of the research literature illustrating why these factors are important to health is required. CIHI's new report, *Improving the Health of Canadians: An Introduction to Health in Urban Places* (Canadian Institute for Health Information, 2006b), is one example of an attempt to make information about the relationship between health and place more accessible to the public.

Summary

Describing wellness has an extensive literature and it has been shown to have several key dimensions that include physical, emotional and psychological, social, intellectual, spiritual, occupational, and environmental attributes. Most of all, wellness is generally viewed from a holistic perspective; it represents a perceived positive state of being and embraces a body-mind-spirit concept. Many factors contribute to wellness in a series of complex and interacting ways, but wellness, like health, is more than the absence of disease; it involves important subjective concepts by individuals about themselves.

Measuring wellness has received much less treatment by researchers and tends to focus on assessments of individuals mainly through the use of questionnaires. Currently, there are several initiatives under way to try to measure wellness concepts at a population or national level. While not discussed in this chapter, it is worth noting that there have also been several approaches to measuring health and wellness at the community level (Hancock, Labonte, and Edwards, 1999; Canadian Institute for Health Information, 2005b).

By contrast, there are numerous studies that measure the determinants of health and wellness at a population level, and much of the research has helped to inform policies related to health promotion. There are well over a dozen so-called determinants, which include income, its distribution and social status, social support networks, education, security of employment and actual working conditions, social environments, physical environments, healthy child development, health services, gender, and culture. Other factors include Aboriginal status; food security; housing quality, affordability, and security; and last, but not least, geography.

Increasingly, researchers and policy makers today are recognizing the importance of place in determining health and wellness. Place involves where individuals live, work, play, and study. How factors vary across space is very much the focus of the *BC Atlas of Wellness*. The maps provided throughout this Atlas ought to be interpreted not discretely, but as simultaneously occurring and dynamic influences operating day-in and day-out. The information upon which the Atlas is based originates from static, cross-sectional data collected at discrete intervals. It is crude, to be sure; but it does give food for thought to imagine the more dynamic aspects of everyday life that so profoundly shape the health and wellness experiences of populations. The focus on wellness draws attention to the fact that health is a resource for everyday living; emphasizing factors that enhance our abilities to thrive (and not simply survive) creates a positive frame of reference for discussion of how public policies can be developed to better nurture the human condition and spirit.


Community Mapping
Sharpie
Permanent Marker