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Promoting well-being: Time for a paradigm shift in health and human services[1]

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Abstract

The promotion of personal, relational, and collective well-being has evolved markedly in the last three decades. However positive and needed, recent developments in health promotion require further conceptual clarification and synergistic applications. To assist with conceptual clarification, this article proposes to distinguish among sites, signs, sources, and strategies of well-being. With respect to applications, progress is discussed along four domains: temporal, ecological, participation, and capabilities. The temporal domain refers to the timing of interventions and entails a continuum from reactive to proactive strategies. The ecological domain pertains to the site of interventions, ranging from person-centered to community-centered. The participation domain refers to voice and choice of citizens and consumers in delivery of services and access to resources. At one end of this continuum there is empowerment, while at the opposite end we see disempowerment and detachment. Finally, the capabilities domain refers to the concentration on either strengths or deficits. This article argues that a singular focus on strength, prevention, empowerment, or community conditions is insufficient. It presents a framework for the conceptual integration of these four approaches, while illustrating the benefits of their synergy and the risks of their fragmentation. It is high time for a paradigm shift in health and human services, and this article argues that only a new approach that focuses on strengths, prevention, empowerment, and community conditions can make considerable progress towards the achievement of well-being for all.

Key Words: *Community conditions, empowerment, health, human services, paradigm shift, prevention, strength-based approach, well-being*

Introduction

To promote well-being we need an understanding of its main constituents. Well-being consists of (a) sites, (b) signs, (c) sources, and (d) strategies. There are three primary sites of well-being (personal, relational, and collective), each of which has specific signs or manifestations, sources or determinants, and strategies. Once we understand what well-being is all about, we can identify the most promising approaches to its maximization. In this conceptual piece I outline a definition of well-being consisting of four Ss (sites, signs, sources, and strategies), following which I describe a new paradigm for health promotion. This new approach is based on SPECs (strengths, prevention, empowerment, and community conditions).

This article contributes to a multifaceted understanding of well-being and identifies promising approaches to its actualization. I discuss implications for action in health and human services, and call for an urgent re-focusing of energies on synergistic approaches that embrace multiple avenues for change.

The sites, signs, sources, and strategies of well-being

Various traditions within the health and social sciences have concentrated on either personal or collective correlates as manifestations of well-being. Whereas psychology has focused on subjective reports of happiness and well-being [1], sociology and public health have focused on collective and objective measures such as longevity and infant mortality [2]. A group of medical sociologists and

investigators has also concentrated on the importance of relationships, or what I call relational well-being [3]. My claim is that the well-being of any one person is highly dependent on the well-being of her/his relationships and on the community in which she/he resides [4]. Well-being may be defined as a positive state of affairs in which the personal, relational, and collective needs and aspirations of individuals and communities are fulfilled [5]. This definition subsumes narrow conceptions of physical and mental health, for they are a part of well-being and not the whole of well-being [6]. Well-being refers to a satisfactory state of affairs for individuals and communities that encompasses more than the absence of disease. There are many aspects of the psychosocial, economic, political, and physical environment that influence the state of well-being; and there are many aspects of well-being that reach far beyond health and encroach into the realm of values, thriving, meaning, and spirituality. My definition of well-being is in line with comprehensive conceptualizations of health promotion put forth by the WHO [7], by the Canadian government [8], and by the new public health paradigm [9–11], all of which emphasize the values of self-determination, participation, community capacity-building, structural determinants, and social justice.

I elaborate on the specifics and interdependence of personal, relational, and collective dimensions of well-being. To facilitate interventions at multiple levels, and to avoid conceptual confusion, I distinguish among sites, signs, sources, and strategies of well-being. These are the parts that comprise the whole of well-being.

Sites of well-being

Sites refer to the location of well-being. Here we concern ourselves with "where" well-being is situated. While we can distinguish among the well-being of a person, a relationship, or a community, they are highly interdependent. As may be seen in Table I, each one of these entities is unique and dependent on the others at the same time. None can be subsumed under the others, nor can they exist in isolation.

The advantage of making a distinction among the various domains is that each one calls for somewhat different intervention strategies. If our locus of attention is exclusively the individual, we neglect the relational and collective domains that impinge on the very well-being of the person we wish to assist. This approach has been recognized in public health as eco-epidemiology or the Chinese boxes paradigm [12].

There is empirical evidence to suggest that the well-being of relationships (relationships where there is caring, compassion, and formal and informal supports), for instance, has beneficial effects on persons [13]. Likewise, there is a wealth of research documenting the deleterious or advantageous consequences of deprived or prosperous communities on individuals, as the case may be [14].

Communities, as sites of well-being, embody characteristics such as affordable housing, clean air, accessible transportation, and high quality healthcare and education facilities. All these factors take place in the physical space of communities. Relationships, in turn, are sites where exchanges of material (money, physical help) and psychological (affection, caring, nurturance) resources and goods occur. Persons, finally, are sites where feelings, cognitions, and phenomenological experiences of well-being reside. We have to be able to honor the uniqueness of the sites and their interdependence at the same time. We can have a community endowed with excellent jobs, schools, parks, and hospitals where many people feel miserable because relationships in the community are acrimonious. If we only thought of well-being in terms of community, we would miss the experiential component of personal well-being and the influential role of relationships in advancing personal satisfaction. Conversely, we can have a select group of people who, despite poor community conditions, experience high levels of well-being. In this case, exclusive focus on the well-being of these people might miss the need to heal, repair, and transform the community conditions that are diminishing the well-being of those who cannot protect themselves from the injuries of poverty, unemployment, discrimination, and lack of affordable healthcare [2,4,6].

Signs of well-being

By signs I refer to manifestations or expressions of well-being at the different sites we explored above. Signs answer the question "how do I know that this site is experiencing well-being?" Table I answers this question for the three domains of well-being. At the personal level, signs of well-being are arrived at by looking at correlates, by asking people to share what they feel and think when they are happy, satisfied, or experience a high quality of life. A variety of research methods have been used to look at personal signs of well-being, including surveys, interviews, observations, and comparative analyses. Similarly, multiple approaches have been used to find out the signs, characteristics, or correlates of well or healthy communities and relationships [15].

Table I. Examples of interdependence among personal, relational, and collective domains in sites, signs, sources, and strategies of well-being.

		Sites of well-being		
		Personal	Relational	Collective
Signs	Personal	Control	Affirming partners	Health and longevity
	Relational	Satisfying relationships	Enduring friendships	Affirmation of diversity and lack of envy
	Collective	Sense of community	Norms of mutual support	Support for poor and universal healthcare
Sources	Personal	Experiences of self-efficacy	Developmental needs met	Personal contribution to commonwealth
	Relational	Nurturance	Prior experiences of respect and affirmation	Appreciation of interdependence
	Collective	High-quality health and education	Norms that promote collaboration	Culture that understands and fosters interdependence
Strategies	Personal	Empowerment	Empathy and social skills	Collective and political intelligence
	Relational	Voice and choice in partnership	Conflict resolution and growth orientation	Social support and rewards for participation in social change
	Collective	Participation in political process	Norms that affirm mutuality and oppose competition	Social movements that fight injustice

A few signs of personal well-being come to the fore: self-determination and a sense of control, self-efficacy, physical and mental health, optimism, meaning, and spirituality. Signs of relational well-being include caring, respect for diversity, reciprocity, nurturance and affection, support, collaboration, and democratic participation in decision-making processes. Manifestations of collective well-being include a fair and equitable allocation of bargaining powers, resources, and obligations in society, gender and race equality, universal access to high-quality educational, health, and recreational facilities, affordable housing, employment opportunities, access to nutritious foods at reasonable prices, safety, public transportation, a clean environment, and peace [2,4,12]. When present, these signs tell us that the needs of individuals and communities are met and fulfilled

Each one of the signs noted above is intrinsically beneficial to the well-being of a particular site (person, relationship, or collective) and extrinsically beneficial to the well-being of the other two sites. For supportive relationships foster self-determination while just communities contribute to personal health through a fair allocation of opportunities in society [6,11].

Sources of well-being

Each one of the sites of well-being and its corresponding signs has particular sources or groups of determinants. Self-determination, for example, derives from prior opportunities to exercise control, voice, and choice. In the relational domain, expressions of caring and compassion derive from positive experiences of trust, nurturance, and affection. Signs of collective well-being, such as universal access to healthcare and high-quality public education, depend on policies that promote social justice, which, in turn, distribute resources through progressive taxation systems [6,11,12,16,17].

Although specific sources refer to particular signs, we have to remember that each sign has multiple sources and that the different determinants always interact. Thus, access to high-quality public education, a collective sign of well-being, enhances opportunities for control and self-efficacy, signs of personal well-being.

Strategies for well-being

The key to successful strategies is that they must be specific enough to address each one of the sites, signs, and respective sources of well-being at the same time. Interventions that concentrate strictly on personal sites neglect the many resources that relationships and communities contribute to personal well-being, as illustrated in Table I. Paradoxically, strategies that concentrate exclusively on personal well-being undermine well-being because they do not support the infrastructure that enhances well-being itself. This has been a major gap in previous efforts to sustain individual well-being through strictly psychological means such as cognitive reframing, positive thinking, information sharing, and skill building. This is in line with recent thinking in public health, articulated forcefully by spokespersons such as Syme [10,18] and Labonte [19]. Individuals cannot significantly alter their level of well-being in the absence of concordant

environmental changes [9]. Conversely, any strategy that promotes well-being by environmental changes alone is bound to be limited. There is ample evidence to suggest that the most promising approaches combine strategies for personal, relational, and collective change [10]. It is not one or the other, but the combination of them all that is the best avenue to seek higher levels of well-being in our three sites of interest.

Integration of sites, signs, sources, and strategies

We can integrate sites, signs, sources, and strategies in the following formulation: The well-being of a *site* is reflected in a particular *sign*, which derives from a particular *source* and is promoted by a certain *strategy*. To wit, personal well-being is reflected in control, which derives from opportunities to exercise voice and choice, and is promoted by empowerment. In this case, the site is personal wellness, the sign is control, the source is opportunities to experience voice and choice, and the strategy is empowerment.

In the relational domain we can integrate the four Ss as follows: Relational well-being is reflected in the presence of supportive relationships, which derive from successful experiences of nurturance and attachment, and is promoted by empathy and opportunities to give and receive caring and compassion. In the collective domain we can claim that collective well-being is reflected in universal access to healthcare, which derives from policies of social justice, and is promoted by social movements that strive to create and improve institutions that deliver services to all citizens, irrespective of means [11,19].

In synthesis, then, the well-being of site q is reflected in sign x, which derives from source y, and is promoted by strategy z. By using this simple formulation, we can integrate a vast amount of research in operational and actionable terms, as exemplified in Table I.

The SPECS of well-being: Investing in strengths, prevention, empowerment, and community conditions

"SPECS" is an acronym for the promotion of well-being; it stands for strengths, prevention, empowerment, and community conditions. In order to advance well-being at the three sites discussed above (personal, relational, and collective), it is necessary to devise strategies that cover the range of domains of well-being, and that attend to the variety of signs and sources. Hitherto, most approaches to well-being have concentrated on single sites and on small groups of signs and sources [4,14]. I submit that a comprehensive and efficacious pathway for the promotion of well-being must attend to four complementary domains: temporal, ecological, participation, and capabilities. While some of these parameters have been invoked in the public health literature before, they have not been integrated in the current form. Syme [10,18] and Labonte [19,20], for instance, insist on the importance of the participation domain, whereas Susser and Susser have emphasized the ecological continuum [12]. Timing of intervention has also been discussed at length, but not integrated with the other three dimensions presented below [21].

These four domains belong in two fields. The contextual field consists of intersecting continua of temporal and ecological domains, creating four contextual quadrants. The affirmation field reflects the interaction of the participation and capabilities domains.

The contextual field

A contextual approach to well-being must account for the role of temporal and ecological variables. The temporal domain spans the continuum of reactive to proactive or preventive approaches. The ecological domain, in turn, covers the full range of interventions, from individual to collective. When the two domains intersect, as may be seen in Figure 1, a contextual field with four quadrants is formed.

The temporal domain. This domain has to do with the timing of interventions. Only a small amount of resources is allocated to prevention in Canada and the United States [22,23]. The vast majority of resources are assigned to rehabilitative costs such as hospital beds, expensive treatments, or therapeutic interventions. This, despite the fact that high-quality preventive interventions have proven efficacious, cost-effective, and enormously more humane than waiting for citizens to develop maladies that medicine and psychology can only treat at very high financial and human costs [24,25]. The reactive approach, a vestige of the still dominant medical model, occludes the need to devote more resources to prevention. For as long as local governments, states, nations, and international bodies neglect prevention and acquiesce to the dictates of the medical model, not much will change in the health and well-being of the population. The status quo will only continue to deprive the poor and underserved of vital services and resources [26].

It is imperative for the health and human services field to pay more attention to the exemplary models
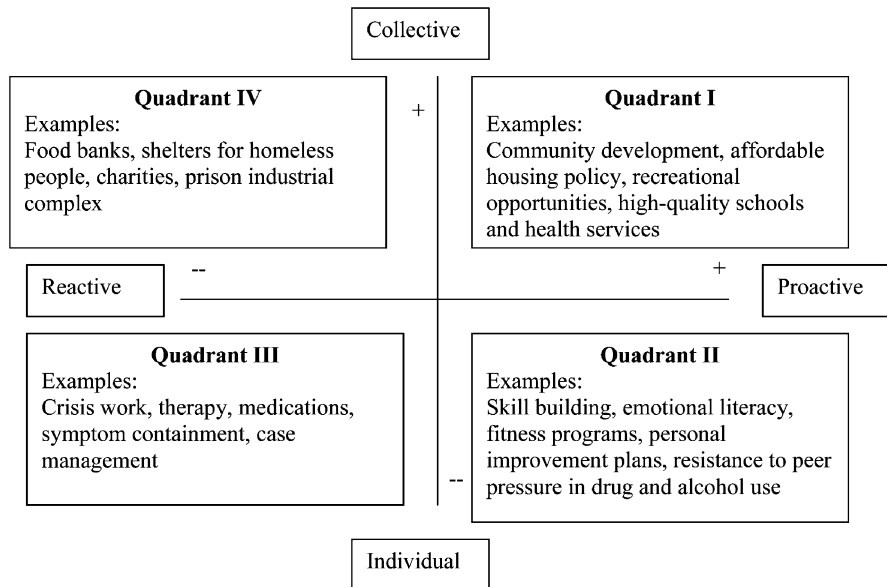
Figure 1. Contextual field in health and human services.

of preventive interventions. The tremendous imbalance between reactive and preventive approaches in favor of the former must be challenged. Health and human services must understand that no mass disorder afflicting humankind has ever been eliminated, or brought under control, by treating the affected individual. Similarly, they must realize that there will never be enough workers to attend to the people afflicted with psychological and physical ailments. The only way to make a dent in the incidence and prevalence of suffering is through prevention [27].

The ecological domain. This continuum is concerned with sites of well-being and their corresponding strategies. Efforts to enhance personal wellness in the absence of corresponding improvements in the social conditions of living are limited at best and injurious at worst [4,6,10,14,18,19]. While working with single individuals may be more convenient than trying to change community conditions and social policies, one must be aware of the long-term repercussions of continuing to focus on a single source of suffering, the person, to the exclusion of sometimes overwhelming environmental factors.

Contextual quadrants. As may be seen in Figure 1, four quadrants are formed by the intersection of the temporal and ecological domains. Clockwise, quadrant I is formed by the intersection of the positive ends of the x and y axes. Examples of collective and preventive approaches include affordable housing policies, provision of high-quality healthcare, incentives to achieve high educational standards, investments in education, family planning, and mental health, as well as progressive taxation policies that distribute wealth among the population [19].

Quadrant II represents interventions that are proactive but person-centered. Examples of such include skill building, emotional literacy, and education for proper eating and exercise to prevent physical illness. Many drug-prevention programs that teach youth resistance skills and knowledge concerning the effects of alcohol, smoking, and illicit drugs fit into this quadrant, as do some programs to enhance the self-efficacy of mothers [24,25].

Quadrant III reflects the medical model tradition whereby the intervention is aimed at containing symptoms and managing crises. Medications, therapy, and crisis intervention are prototypical approaches in this quadrant. Practitioners wait to intervene until patients, clients, or community members complain of an ailment, and this is usually done in a medical, clinic, or community agency setting.

The last quadrant, number IV, is created by the intersection of collective and reactive approaches. Food banks, shelters for homeless people, and in general charity efforts are aimed at alleviating for certain groups the ill effects of social injustice or the unpredictable outcomes of economic downturns.
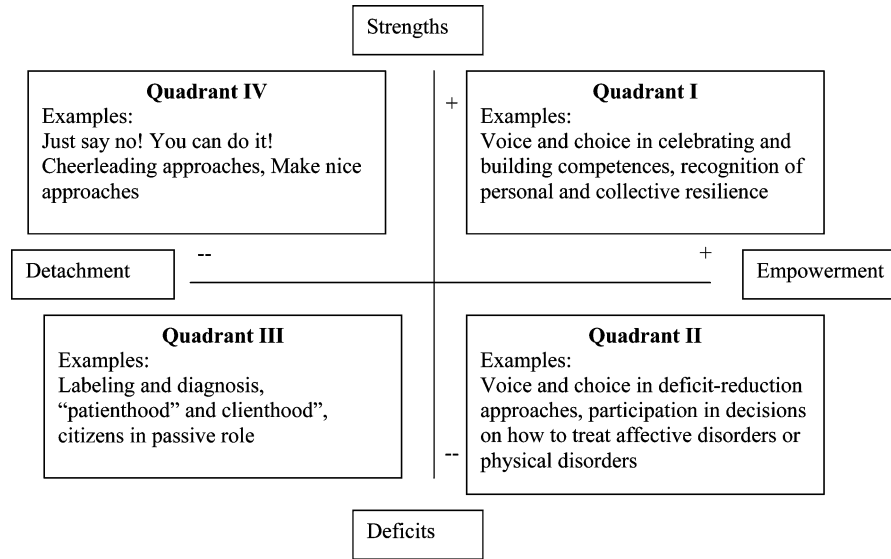
Figure 2. Affirmation field in health and human services.

The affirmation field

To experience well-being, human beings have to experience affirmation first. Affirmation comes, among other things, from an acknowledgment of a person's strengths, voice and choice. Health and human services have been – and many continue to be – notorious for concentrating on deficits and for creating clienthood and patienthood instead of citizenship [4,5]. When empowerment and strengths are promoted, on the contrary, the experience of affirmation grows.

The affirmation field consists of two intersecting continua: the participation and the capabilities domains. Together, they create four distinct approaches to helping and healing.

The participation domain. Citizens are variably involved in services, programs, and policies promoting health and well-being. For the most part, however, they tend to be detached from decision-making processes directly affecting their own health, or the health and well-being of the entire community. Usually, citizens are at the receiving end of decisions made by professionals or politicians – decision that render citizens in the role of clients, patients, or customers but rarely in the role of partner [10,20].

As a result of this culture of patienthood and clienthood, many community residents feel completely detached from the professional, communal, and political processes affecting their lives. This is reflected in the minus end of the x axis in Figure 2. At the other extreme we have feelings and actual experiences of empowerment whereby citizens feel and are in control of helping, healing, and community-building processes.

The capabilities domain. The y axis of Figure 2 depicts the deficit–strength continuum. Few are the professionals who start a relationship with clients based on what the latter are actually doing well. Typically, the opening line of questioning is, explicitly or implicitly, what is wrong with you or what have you done wrong? On account of limited time, physicians and psychologists eager to get to "the bottom of it" refrain from exploring sources and manifestations of resilience. Opportunities to build on strengths, or to promote affirmation, are often missed in the search for pathology.

Affirmation quadrants. Quadrant I in Figure 2 represents interventions aiming to promote voice and choice in celebrating and building competences. People are given an opportunity to exercise control over decisions affecting their lives, whereas modes of help build on former experiences of success.

Quadrant II affords community members voice and choice in methods of deficit reduction. Citizens are made partners in the struggle to combat depression, stress, obesity, or infectious diseases. Quadrant III is the epitome of clienthood and patienthood. Not only are people deprived of an opportunity to participate in helping and healing but most of the focus is on diagnosis, on pathology, and on labeling of maladaptive behavior [28,29].
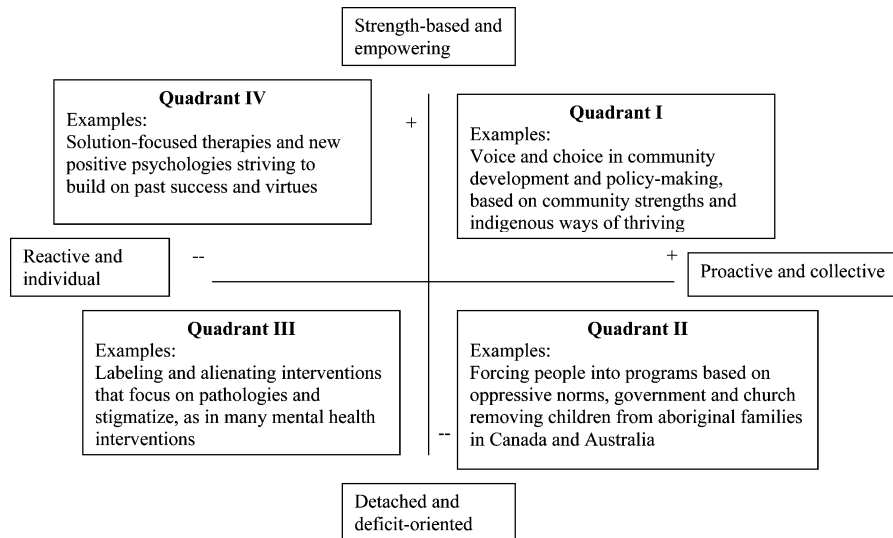
Figure 3. SPECS field in health and human services.

Quadrant IV represents the unique combination of approaches that strive to be positive while keeping the person detached from the change process. Popular yet ineffective campaigns such as "just say no to drugs", or cheerleading efforts such as "you can do it if you want" represent vacuous promises of better health. While positive and effusive, such strategies fail to connect with the real-life experience of youth growing up in drug-infested communities or with the struggle of many people to lower their weight despite lack of access to affordable and nutritious foods and vegetables.

The SPECS field

By combining the contextual domains with the affirmation domains into one plane, we can portray in Figure 3 the SPECS field. The positive ends of the two contextual continua create the positive end of the x axis in Figure 3: proactive and collective interventions. Similarly, the positive ends of the affirmation continua form the positive end of the y axis in Figure 3: strength-based and empowering approaches. The negative end of the former continuum comprises reactive and individual interventions, while at the negative extreme of the latter are detached and deficit-oriented practices.

Quadrant I in Figure 3 fosters voice and choice in community development, policy-making, and wellness promotion. Quadrant II, in turn, addresses community-wide issues, proactively but from a deficit orientation. Efforts in Canada and Australia to educate aboriginal children in Western traditions were "proactive" and "collective" strategies employed by government and church officials.

Colonizers removed aboriginal children from their families in order to educate them in Western traditions. They regarded aboriginal culture as deficient and inferior. Native families did not have a say in the matter, nor did the children, who were often later subjected to abuse and neglect.

Quadrant III in Figure 3 concerns the prototypical medical model, whereby help-seekers become patients in an elaborate system of labeling, diagnosis, and alienation. Quadrant IV embodies strength-based and empowering interventions that are reactive and individual-based. Solution-focused therapy and certain aspects of the new positive psychology [1] represent this modality of helping. While oriented towards resilience and past successes this approach is predicated on individuals knocking on professional doors for help, after a physical or psychosocial problem has set in.

Conclusion

Reactive, individual, alienating, and deficit-based approaches that foster patienthood instead of health, citizenship, and democracy have dominated the field of health and human services for decades [28]. It is time to shift paradigms and give strength-based, preventive, empowering, and community-oriented approaches a chance to promote personal, relational, and collective well-being. SPEC based approaches have proven cost-effective and more humane than the predominant and disempowering medical model [4,5,6,9,10].

To further this emerging paradigm, research and action will have to inform the conceptual framework. Different parameters of the model presented above

have been researched, but in isolation. Exemplary preventive projects, such as the ones led by Olds on the prevention of child abuse [24,25], address maternal behavior but do not alter community conditions. Most programs described in ''The community guide for preventive services'' (www. thecommunityguide.org) and ''Putting prevention into practice'' (www.ahrq.gov/ppip/manual) neglect the participation and capabilities continua of SPEC. We need efforts to combine all the SPEC elements at once. This will require multidisciplinary teams with shared values and thorough training in the four continua of the SPEC model [30].

We need to promote action-research projects that foster individual skills and strive to alter deleterious community conditions at the same time. Hitherto, most programs have concentrated on improving the well-being of the individual but have neglected the community conditions that lead to suffering in the first place. Unaltered, toxic environments produce stress and illness that take a toll on the most resilient people. Can professionals partner with citizens in fostering strengths, prevention, empowerment, and changing community conditions? This is our challenge.

Acknowledgement

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