



CHAPTER ONE

IMAGES OF HEALTH

Joan Arnold
Laurel Janssen Breen

What do you imagine when you think about health—your health? Do you view yourself as healthy? What health goals do you possess now for yourself and your family? Do factors in your community contribute to your personal health and your family's health? Is your community healthy? In your own unique way, how do you define health? These critical questions beckon examination by the client and the health care professional. Searching for their clarification provides opportunities for discovery about images of health and direction for professional health care interactions and interventions. Once conceptualized, an image of health provides direction for health promotion actions.

Health is baffling. Contemporary thinking about health emphasizes empowering nations, community groups, and individuals to realize their own health aims. In the face of widespread interest in defining health at the theoretical level, the development and the use of clinical practice frameworks to support interventions are increasing. These practice frameworks and theoretical models both reflect and affect clients' and health care professionals' *images of health*. This chapter describes ten categories of images of health, each reflecting a unique view (Exhibit 1.1).

Each image category may include aspects that are also found in other images, and some words may have different meanings in the contexts of different images. These images portray health as the antithesis of disease, a balanced state,

EXHIBIT 1.1. IMAGES OF HEALTH.

Antithesis of disease
Balanced state
Growth
Functionality
Goodness of fit
Wholeness
Well-being
Transcendence
Empowerment
Resource

growth, a functional capacity, goodness of fit, wholeness, well-being, transcendence, empowerment, and finally, a resource. Reflecting on these images of health reveals the complexities of health.

Imagining Health

Health is an elusive term because the state of being healthy can be viewed from a multitude of perspectives. Health may be considered a reference for disease, defined by determining forces, or a panacea. It may be thought of as autonomy and integrity projected by the human system. It may refer to the uniquely characteristic strengths of a person, a family, a group or population, a community, a nation, or the world. It may also mean a self-sustaining or self-replenishing capacity. Health may be thought unattainable, impossible to achieve because of limitations, oppression, and depleting forces. Curiously, health care professionals, regardless of discipline, know more about disease, pathology, and dysfunction than they do about health. Although health is valued and desired as a goal, the diagnostic precision found in dealing with conditions of illness, disease, and social problems is not evident in the study of health. Our clients look to us, as providers of health care, to assist them to achieve their desire to be and feel healthy. As clients strive to shape personal pictures of health, the health care professional bears witness to the coalescing of images of health into the client's own unique composite. This unique

image may differ from the health care professional's image of health and expectations for client health. While the client and health care professional interact as partners, the health care professional recognizes these differences and enfold them into the therapeutic process. Inherent in this challenge is the necessity to accept the client's right to self-determination and to commit to assisting the client in reducing barriers and achieving health goals. The images of health presented in this chapter reflect a clustering of views on health. These images are offered to stimulate a re-visioning of health. Health cannot remain an enigma; it stands on its own as a life process, to be imagined and realized within the unique capacity of everything human.

Health as the Antithesis of Disease

In the image of health as the antithesis of disease, health and disease are viewed as opposite states, with health as the absence of disease. Dubos (1965) referred to "the states of health and disease [as] the expressions of the success or failure experienced by the organism in its efforts to respond adaptively to environmental changes" (p. xvii). Here, the conditions of health and disease are expressions of bipolar thinking. In this context a given population's health is measured by its opposite, the population's morbidity and mortality statistics. These indexes of illness and death are used to appraise health and to direct interventions in specific aggregates. Persons suffering from disease were, and still are, ostracized by society. Social standards for health can lead to negative perceptions of persons with diseases that are in contradiction to these standards. Consider the treatment of persons with leprosy, disabling conditions, acquired immunodeficiency syndrome (AIDS), and drug addiction; they are often feared and viewed as not socially acceptable. Their condition or illness is contradictory to what is defined as healthy by society, and their presence threatens the perceived social order.

When health is defined as the absence of disease, evaluative statements about clients are made within the parameters of illness, using a system of disease signs and symptoms. "This definition of health has been largely the result of the domination of the biomedical sciences by a mechanistic conception of man. Man is viewed by physicians primarily as a physico-chemical system" (Smith, 1983, pp. 46–47). Health care professionals are prepared to make evaluative statements of illness by formulating a diagnostic statement from symptomatology and objective data. Such an evaluative statement requires comparisons to established norms. Illness becomes a deviation from these norms. Health then is a condition of the norm, whereas illness falls outside the range of normal. Rather than defining the components of health, the medical model, relying on illness identification, merely identifies health as the

absence of disease. Thus being healthy is being within the range of normal, and more specific parameters are not identified. However, what falls within the medical norm may be nevertheless suboptimal. Then mediocrity becomes an acceptable definition of health, and because of this, the optimal conditions of normal may never be recognized, realized, or individualized.

Health as a Balanced State

The image of health as a balanced state incorporates epidemiology, which provides an important understanding of the relationships among host, agent, and environment in explaining health. *Epidemiology* is the study of patterns of health and the patterns of disease, disability, and death and other problems in populations of persons (Leavell & Clark, 1965). In a broad, widely accepted definition, epidemiology is stated to be “the study of the distribution and determinants of health-related states or events in specified populations and the application of this study to control of health problems” (Last, 1995, pp. 55–56). A major goal of epidemiology is to identify *aggregates*, or subpopulations, at high risk for disease or health-threatening conditions. The intent is to identify risk factors that put the aggregate at risk and then to modify or reduce those risks through preventive interventions. Efforts such as screening, case finding, and health education are geared toward populations most likely to gain from specific strategies developed for a particular disease (Gordis, 1996).

In the epidemiologic framework, health is identified along a health-illness-death continuum. The origins of health and illness are indicative of other processes that occur before the human being is affected. Key to these processes are the interactions of conditions in the environment, factors of the agent for disease, and predisposing genetic forces. “Heredity, social and economic factors, or physical environment may be creating a disease stimulus long before man and stimulus begin to interact to produce disease” (Leavell & Clark, 1965, p. 17). The preliminary interaction of the human host, potential disease agent, and environmental factors in disease production is referred to as the *period of prepathogenesis* (that is, the period before disease). Prepathogenesis is the period of health. The balance among the host, potential agent, and environment is reflective of the equilibrium inherent in the condition of health. It is not until the disease-provoking stimuli produce changes in the human system that the *period of pathogenesis*, or disease, results. The period of prepathogenesis can be thought of as the process in the environment, whereas the period of pathogenesis is the process in the human being, or human system.

Disease is a state of disequilibrium, or *dis-ease*, and health is a state of balance, or equilibrium. Equilibrium is achieved through the interaction of the mul-

multiple factors and forces that influence and contribute to health. The balance that is health is reflected in the nature and intensity of these interactions. Physical, physiological, psychological, social, cultural, spiritual, political, and economic forces interact and contribute to the unique image of health for each individual, family, group, and community. Health is a singular condition and a condition of society as well as a balance of these forces.

Cultural ideologies and traditions also influence the image of health as balance. For example, the harmony of yin and yang is balance. Yin and yang have been described as passive and active, feminine and masculine, nurturing and stimulating, and earthly and heavenly. Energy is balanced when these seemingly opposite forces work together. Imbalances between yin and yang are believed to be manifested in the ways internal organs function and can result in disturbances of vital energy, represented on the body's acupuncture meridians. Ayurveda, an ancient medical system that originated in India, emphasizes the equal importance of body, mind, and spirit (National Center for Complementary and Alternative Medicine [NCCAM], 2000). To a practitioner of Ayurveda, imbalances in *doshas*—physiological principles, or bodily humors—can lead to specific diseases. Various foods and emotions are believed to result in imbalances. Furthermore, the dominant medical system in Europe, from ancient Greek times to contemporary ones, emphasizes “the belief that ill health resulted from an imbalance of the body's four humors (blood, phlegm, yellow bile, and black bile)” (NCCAM, p. 8). “Habits and beliefs of people in a given community are not separate items but are the elements of a cultural system which determine their response to any disease. Each culture has its own ways of organizing experiences pertaining to health and disease” (Singh, 2001, p. 39).

Health as Growth

The foundation of the view that sees health as growth is found in the beliefs of noted developmental theorists (for example, Dewey, 1963; Piaget, 1963; Elkind, 1981; Erikson, 1963; Duvall, 1985; Havighurst, 1972). This image leads to a further view of health as the successful fulfillment of certain tasks appropriate to particular life stages. Persons are seen as having a capacity for growth that can be enhanced and supported; this development is seen as an ongoing process that occurs continuously and systematically throughout the life span. Growth is viewed as progressive. Health is seen as being intimately determined by individual lifestyle and behavioral choices. Interventions at critical life stages are believed to be the most effective and to foster optimal growth. Through identification of certain *transition points*, the unique needs, behaviors, and motivations of certain populations are targeted. In this framework, periods of transition involve restructuring and

reorganization of both the inner and outer worlds of an individual. Frequently, these periods arise when there is an unfolding of events in which the status quo is challenged. Oftentimes this means new opportunities for enhancing growth and coping (Cowan & Cowan, 2003).

The concept that overall wellness in each life stage involves the achievement of certain cognitive, physiological, and psychological competencies is integral to a life-span approach to health as growth. Established norms are used to measure growth at each stage. Following an established pattern of expected progression through the stages is viewed as desirable and is anticipated. The movement from one stage of growth to another is predicated on some of the life skills and tasks accomplished in an earlier stage. The “failure” to achieve certain developmental skills during a particular stage may be viewed as impeding growth into the next stage.

The way the concept of aging is visualized in the framework of a life-span definition of health demands attention. In its most narrow definition, old age is delineated as the end stage of life, a time of anticipated decline when dependency and helplessness are expected outcomes. It is viewed as a time of final goal attainment, thus avoiding any need to establish health challenges for this population. From a broader viewpoint, aging is a complex cultural issue and is not defined merely by biological parameters. Although they may have altered physical abilities and changing expectations, aging persons retain the capacity for full participation in life. *Aging* in this view is an imprecise term that can be understood as both a loss and a goal. The process of aging is the process of life. Although older Americans today are considered healthier, wealthier, and better educated than the older members of previous generations (Federal Interagency Forum on Aging-Related Statistics, 2004), disparities exist, particularly among those with limited education, women, and minorities.

Over the course of the last three decades a body of literature has developed that is apart from the mainstream, disease-oriented framework and that has begun to describe the experiences of people who have coped successfully with traumatic events. Although much remains to be discovered about how people bounce back from negative events, this literature has explored trauma as an opportunity for psychological growth, which comes about through the challenge and struggle presented by the traumatic event itself (Tedeschi & Calhoun, 1995). Posttraumatic growth is variously seen as an outcome and as a process. A variety of terms have been identified to acknowledge the phenomenon in which growth and change develop and even advance beyond prior levels of adaptation after exposure to undesirable or extreme events. These terms include *resilience*, *hardiness*, and *thriving*.

When considering how some individuals, families, and larger social systems overcome crises and ongoing adversity while others become depleted and shat-

tered, Walsh (2003) asserts that resilience is the key. From this strengths-oriented approach, life challenges become opportunities for growth. Resilience research has moved beyond considering it as a personal psychological trait and now sees it as a dynamic process (Masten, 1999). Resilience is the capacity to bounce back from adversity and grow through it as its effects are mitigated by protective and vulnerability factors (Luthar & Zelazo, 2003).

Hardiness has been described by Kobasa (1979) as a grouping of personality traits that includes control over life events, a life commitment, and a personal view of change as challenge. Hardiness is seen as a variable that influences the effects stress may have on an individual's physical and mental health. People who are hardy are perceived as having an increased ability to withstand stress (Low, 1996).

Thriving, which has been derived from resilience research, has been conceptualized as a dynamic process of adaptation whereby challenge provides an opportunity for growth and greater well-being. Thriving goes beyond coping and homeostasis to become transformative. It involves cognitive changes, a reexamination of self, and an ability to mobilize resources needed to deflect the impact of a threat or risk (O'Leary & Ickovics, 1995).

When one views *health-within-illness* (Moch, 1998) an opportunity unfolds to view illness as a potential growth catalyst. Health promotion efforts may have negated or ignored these opportunities in the past. However, if health and illness coexist, then within illness is the possibility of realizing health through a sense of meaningfulness, self-knowledge, positive change, and redefinition of life events. Likewise, at the end of life, efforts such as the hospice movement promote health when assisting individuals and families to find meaning in imminent death and to live well with terminal illness. "Our ultimate goal as a society and as members of communities surely is to maximize human development and the achievement of full human potential" (Hancock, Labonte, & Edwards, 1999, p. 522).

Health as Functionality

In the image of health as functionality, health is seen as the capacity to fulfill critical life functions. Functional health patterns for individuals include all activities that influence a person's relationship with the environment. Physiological functions include digestion, hydration, sleep, elimination, and circulation. Psychological functioning encompasses behavior, communication, and emotional development. Fulfillment of these functions defines a healthy individual. Likewise, families have functions to fulfill, including the capacity to nurture their members through physical, emotional, educational, and social support activities. Further, communities function to provide their members with resources to sustain themselves. A community is vital when members can meet their needs and in turn participate in the

community's further development. At the global level, nations participate in achieving shared responsibility for mutual health goals for their respective and collective populations.

Functionality is viewed as the ability to carry out a given task. When the functional capacity of individuals, families, groups, and communities is limited, health is altered, and adaptation is necessary to adjust to the environment and fulfill functions. However, adaptation need not be viewed from such a narrow vantage point. It encompasses not only modification of the individual but also alteration of that individual's environment. From this perspective, disability is viewed as a *different ability*, one that requires an altered environment so that a person can achieve vital life functions (that is, the environment is made *accessible*, available to those with different abilities). Persons with disabling conditions then become equally able.

Rehabilitation, a level of prevention, focuses on recovering remaining capacity to maintain function. The strengths and capacities of the individual are realized differently to restore function, even if that function is modified. Recovering the capability to function as independently as possible enables the person, family, group, or community to depend less on other forms of support. Returning function, even if modified, enables social utility and a sense of purpose.

Participation in health activities depends on an individual's overall health function skills. Health literacy, for example, is a major skill necessary for comprehending information directed at improving health (Ratzan, 2001). Health literacy is the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions (Ratzan & Parker, 2000). The National Adult Literacy Survey (NALS) has raised serious concerns about marginal health literacy skills among many Americans and about these individuals' ability to participate adequately in their health care (Ad Hoc Committee on Health Literacy for the Council on Scientific Affairs, American Medical Association, 1999). It is estimated that nearly half of all American adults, ninety million people, have difficulty understanding and acting on health information (Nielsen-Bohlman, Panzer, & Kindig, 2004). Health literacy therefore affects functional health.

Health as Goodness of Fit

The fit between the person and the surrounding environment is often imperceptible, as each is embedded in the other. It becomes impossible to distinguish the reciprocal relationship in this joining. The image of health as goodness of fit considers the meshing of the determining factors of health. Human biology, environment, health care, and lifestyle have been identified as the four major determinants of human health (Lalonde, 1974). Each of these determinants is

important; however, special attention is now being given to the influence of individual lifestyle on personal health. This focus on lifestyle is inevitable given that the human life span is increasing, chronic disease has become a greater factor than communicable disease in morbidity and mortality, and the health care system has become increasingly focused on costs.

Lifestyle is about choosing. Individuals, families, groups, and communities choose options that set into motion unique interactions of factors and forces that have the potential to produce health or illness. Much progress in the overall major decline in death rates for the leading causes of death among Americans has been traced to reduction in risk factors. *Healthy People 2010* (U.S. Department of Health and Human Services, 2000) delineates health objectives for improving longevity and decreasing health disparities in our nation. Despite these advances resulting from preventive interventions, the United States continues to be burdened by preventable disease, injury, and disability. Focusing on lifestyle alone, however, rather than viewing health as an outcome of a multiplicity of determinants, can easily result in “blaming the victim.” When the complex mix of biological, psychological, social, cultural, and political factors is underacknowledged and underestimated, the individual is held solely responsible for risk-taking behaviors and health outcomes.

Lifestyle is only one of the four major factors that determine health. Lifestyle is about choosing, to whatever extent possible. However, certain biological factors, although modifiable, are largely uncontrollable. In addition, environmental determinants of health are often negotiated at the public policy level, leaving individuals, families, groups, and communities without a sense of personal control. Environmental factors such as poverty, racism, and resource allocation challenge the individual’s potential for health and limit choice. Also, the availability, accessibility, affordability, appropriateness, adequacy, and acceptability of health care (National Institute of Nursing Research, 1995) can enable or diminish health potential. No one factor alone determines an individual’s health, which is shaped by the interlocking of these forces. Yet there is opportunity for change to occur at the point these factors interface.

The environment, a critical determinant of health, cannot be viewed in isolation any more than lifestyle can. The reciprocal relationship between people and their environment is emphasized in the ecological models of health. Recognition of the influences of intra- and interpersonal factors, community and organizational factors, and public policy is viewed as necessary to a full understanding of health-related behaviors and interventions (McLeroy, Bibeau, Steckler, & Glanz, 1988).

The preparation of public health professionals for addressing the public’s health (Gebbie, Rosenstock, & Hernandez, 2003) relies on an understanding of the various determinants of health. The relationships and processes that link these

forces are best described in an ecological model of health. Individual behavior; social, family, and community networks; living and working conditions; and broad social, economic, cultural, health, and environmental conditions at all levels of development and over the life span are linked in this model. The fit among these factors and forces shapes an understanding of the determinants of population health.

Health as Wholeness

A holistic image of health is central to healing and complementary health care delivery. Appreciating wholeness is enhanced by a framework that supports multiple interactions (Bertalanffy, 1968; Laszlo, 1972). The idea that every aspect of a human being, family, or community is linked and interacting arises from a systems theory orientation. A human being is constructed of subsystems that work together, and he or she is at the same time a subsystem of the family and community, which also are interacting parts of each other.

Each system is simultaneously a subsystem and a suprasystem. Boundaries define each system and allow, through their regulation, the flow of inputs and outputs that maintain energy and enable growth. In this framework, health can be viewed as system integrity and unity. Supporting the integrity of the human system is the focus for promoting and maintaining health.

Human beings are considered whole (that is, more than and different from the sum of their parts). “The whole has a unity, organization, and individuality that is not discoverable by means of the analysis of its parts. In fact, the analysis of the parts of the organism results in decreased perceptions of the qualities of the whole” (Blandino, 1969, quoted in Smith, 1983, p. 77). Employing the framework of Maslow (1968), Smith (1983) considers health to be the complete development of the individual’s potential. Smith’s eudaimonistic model focuses on the entirety of the organism, including the physical, social, aesthetic, and moral—not just the behavioral and physiological—aspects. In the eudaimonistic sense, health is wholeness. To be healthy is a goal toward which the human system strives.

Human systems are no longer viewed in isolation. Individual health is influenced by family health, and one member’s health influences the health of other family members. Likewise, families are viewed within the contexts of groups, communities, and societies; families contribute to the health indicators of larger systems. Nations are viewed within the context of world health, contributing to and being influenced by the whole globe. No longer can health be solely determined by individual indicators. There is growing evidence that individual health and community health are interdependent. This awareness is reflected in the current understanding of population health. The key elements of population health

assessment are aggregated health characteristics and disparities among groups; environmental, social, and economic health determinants; inequalities of opportunity; and community governance and the degree of distribution of power (Hancock, Labonte, & Edwards, 1999).

Health as Well-Being

Health is defined in the Preamble to the Constitution of the World Health Organization (WHO) (signed in 1946 and ratified in 1948) as follows: “Health is a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity” (WHO, 1947). Freedom from disease and illness implies an ideal state among three significant sources of well-being—physical well-being, mental well-being, and social well-being. Referring to health as a “complete” state may mean that health requires no improvement and “that anything less than complete well-being is not health” (Buetow & Kerse, 2001, p. 74). Curiously, following this line of inquiry may result in the negation of health promotion efforts, because health cannot be improved. Bok (2004) asserts that defining health as “complete . . . well-being” may make the term unsuitable for either measuring or comparing states of health. “Even if someone did achieve such a state of complete health, it would be short-lived; and there would be no chance of finding members of any group, let alone inhabitants of a society or a region, enjoying such a felicitous state simultaneously” (p. 7).

Dunn (1961) uses this WHO definition to expand on the idea of *high-level wellness*, in which the term *health* implies being well not only in the body and mind but also within the family and community and having a compatible work interest. “High-level wellness for the individual is defined as an integrated method of functioning which is oriented toward maximizing the potential of which the individual is capable. It requires that the individual maintain a continuum of balance and purposeful direction within the environment where he is functioning” (pp. 4–5). In effect, health is viewed as balance along a goal-directed continuum within the context of the environment. The dynamic nature of health is implied as health potential is maximized. In other words, rather than being a complete static state, health involves maintaining completeness on an ongoing basis. Balance and dynamism are combined while a person, family, group, or community moves purposefully toward a goal.

Often what people describe as “feeling healthy” is a subjective sense of well-being—a subjective interpretation of personal indicators that produce a vague sense that everything is all right. Although the actual structure of general well-being is not clearly understood, it is thought to include the following contributors: emotions, beliefs, temperaments, behaviors, situations, experiences, and health

(Wheeler, 1991). *Well-being* is an imprecise term subsuming both subjective and objective definitions and methods of measurement. It may include self-reports of satisfaction and dissatisfaction, the presence or absence of a persistent mood level or transient emotional state, external environmental conditions, and biochemically related behavior (Kahn & Juster, 2002).

It is known that different individuals experience the sense of well-being in very different ways. The pursuit of well-being may include no formal definition, no clear-cut guidelines. However, the individual does know and understand some means for attaining this state. Perhaps it is not necessary or even possible to have a precise and objective definition of certain human experiences.

For many persons, humor is an important aspect of achieving well-being. In attempting to comprehend and live through the myriad of life experiences, people find that perceived reality can be altered through humor and its outward expressions. Humor is understood as a powerful tool, affecting both neurological and physiological transmissions in the body. It can reduce tension and frustration and startle a person out of complacency. Laughter and humor are powerful expressions that add vitality and “joy” (Cousins, 1979) to the experience of health and life.

Health as Transcendence

To view health as transcendence is to see the human potential for growth and development as limitless. Any boundaries of mind and body are believed to be self-imposed. According to this framework, human beings and intervention modalities are continuously evolving. Health is this process of self-discovery. Understanding on a cognitive level is not necessary for an intervention to be therapeutic. Some aspects of healing are experienced and understood by the client and health care professional at different levels of awareness. Persons are presented with a multitude of choices during their lifetimes. Moving outside personal comfort zones and stretching beyond these perceived boundaries can promote insecurity. Therefore, redefining health involves loosening boundaries and undergoing transformation. Support in this process is desirable and augmenting.

Health is seen as interrelated with the larger universe, integrating emotional and spiritual factors. The *self* is experienced and explored based on a definition that far transcends its ordinary definition; self becomes a “manifestation or expression of this much greater ‘something’ that is our deeper origin and destination” (Lawlis, 1996, p. 5). The process inherent in *body-mind-spirit* is understood as a unified whole that has great potential for experiencing, altering, and expressing health.

The perceived meaning that one attaches to an experience or event is recognized as having an integral connection to one’s overall health experience. These

perceived meanings affect both one's choices and the impacts of health interventions. When exploring the relationship between spirituality and health, it is generally acknowledged that the concept of spirituality lacks an accepted clear definition and is highly personal and contextualized (Coyle, 2001). However, it is also recognized that spirituality "motivates, enables, empowers, and provides hope" (p. 592). Spirituality has further been understood as "one's inward sense of something greater than the individual self or the meaning one perceives that transcends the immediate circumstances" (U.S. Office of Alternative Medicine, 1994, p. 8). It is this sense of meaning and purpose that supports an individual's ability to gain some control and mastery over his or her circumstances. A spiritual healing philosophy of health acknowledges the healing forces of modalities such as prayer, meditation, and focused thought (Institute of Medicine, 2005).

Health as Empowerment

A strong link between individuals' or communities' sense of power and the level of health they experience has been identified (Robertson & Minkler, 1994; Minkler, 1999). This power has been closely associated with the perceived degree of life *control* and *mastery*. Powerlessness has been identified as a broad-based risk factor for the development of disease. The empowerment process, as a health promotion intervention strategy, has been correlated with improving the health of populations (Wallerstein, 1992). Health professionals must respect and acknowledge the significance of clients' right to "name their own experience" as an integral part of the empowerment process. Without this, the professional risks subjectively overwhelming or affecting the lives of others by setting up a health agenda "for" clients that they "must" follow (Labonte, 1994).

Movement toward health evolves from a fully engaged sense of self. Definition and direction for health come from this strength. Change occurs as individuals and communities, in partnership with the health care professional and others, work toward the implementation of this personal vision of health.

Empowerment in its fullest meaning is context bound. It extends to include an awareness of all the forces that individuals, families, groups, and communities face as they attempt to transform their reality (Airhihenbuwa, 1994). Culture is one of these forces. Health experiences and choices originate within a cultural perspective. Cultural values, attitudes, and behaviors are seen as an integral part of a personal definition of health and disease. The empowerment process is expanded through actions that focus on improving the health of communities. Targeting only individual change dilutes the process. "Hence the empowerment process is maximized when community residents at large become mobilized around health concerns and initiate collective actions for well-being of the entire community"

(Braithwaite, Bianchi, & Taylor, 1994, p. 414). Owing to the interrelatedness of all people, health is a universal experience.

The view of health as empowerment includes the belief that individuals possess numerous and diverse self-care abilities that contribute to determining their health. Persons require certain self-care skills to feel in control and to direct their own life course, and community change depends on the ability of the community's members to self-direct. Self-care involves competency, which comes about as professionals transfer necessary skills and knowledge to individuals and communities. Much of the provision of health can now be seen as within the grasp of the consumer.

The ability to control and shape this vision is dependent on a redistribution of power within the health care system. Power is transferred as the client determines health actions and as the system of health care becomes accountable for providing client-focused care. With whom, then, does the responsibility for health lie? Although there is strong support for health promotion approaches stressing both personal and a broader social responsibility, it is actually the coalescing of these forces that permits "the creation of healthy public policies and health-promoting environments, within which individuals are better able to make choices conducive to health" (Minkler, 1999, p. 135).

Health as a Resource

In a discussion of health within the context of health promotion, the World Health Organization's Ottawa Charter broadened the conceptualization of health to include an understanding of the social, political, and economic determinants of health. In order to reach a state of health, "an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. Health, is therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities" (WHO, 1986, p. 1).

The idea of health as a resource for living expands the definition of health and its determinants to include the context in which health, or nonhealth, is considered and goes beyond an emphasis on individual lifestyle strategies to achieve health (Robertson & Minkler, 1994). As a resource for everyday living, health is not a state or absolute condition but rather the dynamic capability to deal with life's challenges and care for oneself. Health is competence; a well of strengths, some apparent and some unrecognized but all able to be cultivated and actualized. This resource embodies capacities that are usable, untapped, and potential. An inventory of strengths enables every human system to kindle its resource. Health is a life force for engaging in an evolving process of development.

This image of health as a resource for everyday living extends to community, society, and world proportions. “WHO and other UN-sponsored agencies such as the United Nations Development Program (UNDP) and the World Bank have recognized that health is central to human development, not only at the individual level, but also in terms of global macrosystems and social stability” (Shinn, 1999, p. 117). The editors of a Pan American Health Organization (PAHO) constitutional study on the right to health care have stated: “Health provides both the foundation for a just and productive society and the cornerstone of an individual’s chance to develop his or her full potential. A population that is not healthy cannot learn, cannot work, cannot develop” (Fuenzalida-Puelma & Connors, 1989, p. xv). Health as a resource therefore integrates social, cultural, and political dimensions and includes equity (the right to equal and adequate access to health); integration of health measures across the continuum from promotion to prevention to recovery to survivorship; participation (mutual responsibility between systems and society); and efficiency (appropriate use of available resources) (adapted from WHO as cited in Shinn, 1999). Personal, community, societal, and global health are interconnected and inseparable resources.

Summary

There are many ways to envision health. Each frame of reference creates a different image. Images of health influence personal decision making as well as the establishment of health policies and programs at local, national, and global levels. The health care system, from the smallest unit of service to the entire system, reflects images of health. Health is dynamic. The possibilities for blending and exploring new images of health are endless. As health is redefined, people and communities have greater opportunities to expand its meaning and significance. Health care professionals protect the entitlement to health.

References

- Ad Hoc Committee on Health Literacy for the Council on Scientific Affairs, American Medical Association. (1999). Health literacy: Report of the Council on Scientific Affairs. *JAMA*, *28*, 552–557.
- Airhihenbuwa, C. O. (1994). Health promotion and the discourse on culture: Implications for empowerment. *Health Education Quarterly*, *21*(3), 345–353.
- Bertalanffy, L. V. (1968). *General system theory*. New York: Braziller.
- Bok, S. (2004, October). *Rethinking of the WHO definition of health* (Harvard Center for Population and Development Studies, Working Paper Series, Vol. 14, No. 7). Retrieved November 6, 2005, from http://www.hsph.harvard.edu/hcpds/wpweb/Bok_wp1407_2.pdf

- Braithwaite, R. L., Bianchi, C., & Taylor, S. E. (1994). Ethnographic approach to community organization and health empowerment. *Health Education Quarterly*, 21(3), 407–416.
- Buetow, S. A., & Kerse, N. M. (2001). Does reported health promotion activity neglect people with ill-health? *Health Promotion International*, 16(1), 73–78.
- Cousins, N. (1979). *Anatomy of an illness as perceived by the patient: Reflections on healing and regeneration*. New York: Norton.
- Cowan, P. A., & Cowan, C. P. (2003). Normative family transitions, normal family process, and healthy child development. In F. Walsh (Ed.), *Normal family processes* (3rd ed., pp. 424–459). New York: Guilford Press.
- Coyle, J. (2001). Spirituality and health: Towards a framework for exploring the relationship between spirituality and health. *Journal of Advanced Nursing*, 37(6), 589–597.
- Dewey, J. (1963). *Experience and education*. New York: Collier Books.
- Dubos, R. (1965). *Man adapting*. New Haven, CT: Yale University Press.
- Dunn, H. (1961). *High-level wellness*. Arlington, VA: Beatty.
- Duvall, E.R.M. (1985). *Marriage and family development* (6th ed.). New York: HarperCollins.
- Elkind, D. (1981). *Children and adolescents* (3rd ed.). New York: Oxford University Press.
- Erikson, E. H. (1963). *Childhood and society* (2nd ed.). New York: Norton.
- Federal Interagency Forum on Aging-Related Statistics. (2004). *Federal forum reports Americans aging well, but gaps remain*. Retrieved February 17, 2005, from <http://www.agingstats.gov/chartbook2004/pr2004.html>
- Fuenzalida-Puelma, H., & Connors, S. (Eds.). (1989). *The right to health in the Americas*. Washington, DC: Pan American Health Organization.
- Gebbie, K., Rosenstock, L., & Hernandez, L. M. (Eds.). (2003). *Who will keep the public healthy? Educating public health professionals for the 21st century*. Washington, DC: National Academies Press.
- Gordis, L. (1996). *Epidemiology*. Philadelphia: Saunders.
- Hancock, T., Labonte, R., & Edwards, R. (1999). Indicators that count! Measuring population health at the community level. *Canadian Journal of Public Health*, 90 (Suppl. 1), 522–526.
- Havighurst, R. J. (1972). *Developmental tasks and education* (3rd ed.). New York: McKay.
- Institute of Medicine. (2005). *Complementary and alternative medicine in the United States*. Washington, DC: National Academies Press.
- Kahn, R. L., & Juster, F. T. (2002). Well-being: Concepts and measures. *Journal of Social Issues*, 58(4), 627–644.
- Kobasa, S. C. (1979). Stressful life events, personality and health: An inquiry into hardiness. *Journal of Personality and Social Psychology*, 37(1), 1–11.
- Labonte, R. (1994). Health promotion and empowerment: Reflections on professional practice. *Health Education Quarterly*, 21(2), 253–268.
- Lalonde, M. (1974). *A new perspective on the health of Canadians*. Ottawa: Government of Canada.
- Last, J. M. (Ed.). (1995). *A dictionary of epidemiology* (3rd ed.). New York: Oxford University Press.
- Laszlo, E. (1972). *The systems view of the world: The natural philosophy of the new developments in the sciences*. New York: Braziller.
- Lawlis, G. F. (1996). *Transpersonal medicine: A new approach to healing the body-mind-spirit*. Boston: Shambhala.
- Leavell, H. R., & Clark, E. G. (1965). *Preventive medicine for the doctor in his community: An epidemiologic approach*. New York: McGraw-Hill.

- Low, J. (1996). The concept of hardiness: A brief but critical commentary. *Journal of Advanced Nursing*, 24(3), 588–590.
- Luthar, S. S., & Zelazo, L. B. (2003). Research on resilience. In S. S. Luthar (Ed.), *Resilience and vulnerability: Adaptation in the context of childhood adversities* (pp. 510–549). New York: Cambridge University Press.
- Maslow, A. H. (1968). *Toward a psychology of being* (2nd ed.). New York: Van Nostrand Reinhold.
- Masten, A. S. (1999). Resilience comes of age: Reflections on the past and outlook for the next generation of research. In M. D. Glantz & J. L. Johnson (Eds.), *Resilience and development: Positive life adaptations* (pp. 281–296). New York: Kluwer Academic/Plenum.
- McLeroy, K. R., Bibeau, D., Steckler, A., & Glanz, K. (1988). An ecological perspective on health promotion programs. *Health Education Quarterly*, 15, 351–378.
- Minkler, M. (1999). Personal responsibility for health? A review of the arguments and the evidence at century's end. *Health Education & Behavior*, 26(1), 121–141.
- Moch, S. D. (1998). Health-within-illness: Concept development through research and practice. *Journal of Advanced Nursing*, 28(2), 305–310.
- National Center for Complementary and Alternative Medicine. (2000). *Expanding horizons of health care: Five-year strategic plan 2001–2005* (NIH Publication No. 01-5001). Washington, DC: U.S. Department of Health and Human Services, Public Health Service, National Institutes of Health.
- National Institute of Nursing Research. (1995). *Community-based health care: Nursing strategies: National nursing research agenda*. Bethesda, MD: Author.
- Nielsen-Bohman, L., Panzer, A. M., & Kindig, D. A. (Eds.). (2004). *Health literacy: A prescription to end confusion*. Washington, DC: National Academies Press.
- O'Leary, V. E., & Ickovics, J. R. (1995). Resilience and thriving in response to challenge: An opportunity for a paradigm shift in women's health. *Women's Health: Research on Gender, Behavior, and Policy*, 1(2), 121–142.
- Piaget, J. (1963). *The origins of intelligence in children*. New York: Norton.
- Ratzan, S. (2001). Health literacy: Communication for the public good. *Health Promotion International*, 16(2), 207–214.
- Ratzan, S. C., & Parker, R. M. (2000). Introduction. In C. R. Selden, M. Zorn, S. C. Ratzan, & R. M. Parker (Comps.), *Current bibliographies in medicine: Health literacy* (NLM Publication No. CBM 2000–1). Bethesda, MD: U.S. Department of Health and Human Services, National Library of Medicine.
- Robertson, A., & Minkler, M. (1994). New health promotion movement: A critical examination. *Health Education Quarterly*, 21(3), 295–312.
- Shinn, C. (1999). The right to the highest attainable standard of health: Public health's opportunity to reframe a human rights debate in the United States. *Health and Human Rights*, 4(1), 114–133.
- Singh, A. (2001). Women's illnesses: The Indian male perspective a search for linkage with Vedic concept of health & Hindu mythology. *Bulletin of the Indian Institute of History of Medicine*, 31(1), 39–56.
- Smith, J. A. (1983). *The idea of health: Implications for the nursing professional*. New York: Teachers College.
- Tedeschi, R. G., & Calhoun, L. G. (1995). *Trauma and transformation: Growing in the aftermath of suffering*. Thousand Oaks, CA: Sage.
- U.S. Department of Health and Human Services. (2000). *Healthy people 2010: Understanding and improving health*. Washington, DC: U.S. Government Printing Office.

- U.S. Office of Alternative Medicine. (1994). *Alternative medicine: Expanding medical horizons: A report to the National Institutes of Health on alternative medical systems and practices in the U.S.* Washington, DC: Author.
- Wallerstein, N. (1992). Powerlessness, empowerment, and health: Implications for health promotion programs. *American Journal of Health Promotion*, 6(3), 197–205.
- Walsh, F. (2003). Crisis, trauma, and challenge: A relational resilience approach for healing, transformation, and growth. *Smith College Studies in Social Work*, 74(1), 49–71.
- Wheeler, R. J. (1991). The theoretical and empirical structure of general well-being. *Social Indicators Research*, 24, 71–79.
- World Health Organization. (1947). Constitution of the World Health Organization. *Chronicle of the World Health Organization*, 1(1–2), 29–43.
- World Health Organization. (1986). *Ottawa charter for health promotion* (WHO/HPR/HEP/95.1). Geneva: Author.