2 MENTAL HEALTH AND WELLBEING

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INTRODUCTION

This chapter explores the usefulness, within occupational therapy, of the concept of wellbeing. First, the association between health and wellbeing is considered, and the relationship between wellbeing and *mental* health is then examined in greater detail. This includes reflection on how wellbeing relates to occupational justice, social inclusion, citizenship, and recovery. Wellbeing is presented as a contested social construct with no fixed meaning. Within this context an occupational perspective of wellbeing is presented, emphasizing the role of occupation in the human drive to survive and flourish, and the relevance of this to broader political agendas concerning wellbeing is explored. Finally, some methods of measuring wellbeing are highlighted.

HEALTH AND WELLBEING

Wellbeing and health have been bound together conceptually since the World Health Organization (WHO) defined health as 'a state of complete physical, mental, and social wellbeing and not merely the absence of disease or infirmity' (WHO 1948). This definition ambitiously proposed a holistic concept of health and wellbeing, established wide parameters for considering what constitutes human health, and recognized socioeconomic factors as the legitimate concern of health services (Barry and Yuill 2012). However, the WHO definition has been criticized for its impracticality and for appearing to correspond more to happiness than health. Huber et al. (2011) suggest it is no longer fit for purpose because it does not accommodate the fact that ageing with chronic illness is increasing worldwide. They propose shifting the emphasis towards seeing health as a person's capacity to adapt and self-manage in the face of social, physical, and emotional challenges, with fulfilment and a sense of wellbeing. This offers a dynamic view of health that has much in common with resilience, which is the capacity to maintain and restore one's equilibrium through coping and

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social connectedness. (Resilience is also discussed in the context of the emotional health and wellbeing of children and young people, in Ch. 25.) Huber et al. (2011) describe a person's sense of coherence as a crucial factor in their health; seeing this as a capacity for coping, recovering from stress, and ultimately for experiencing wellbeing.

The word 'complete' in the WHO definition also attracts criticism, on several counts. Not only is it deemed impracticable because it is not measurable, but also because it would result in much of the world's population being classified as unhealthy most of the time. Furthermore, it is suggested that the WHO definition has unintentionally contributed to the medicalization of society by supporting the tendencies of the medical profession and pharmaceutical industry to diagnose and treat conditions not previously defined as health problems (Huber et al. 2011). While the WHO's definition of health highlighted the *importance* of wellbeing, it also instigated the entanglement of health with wellbeing. One unfortunate outcome of this has been the tradition that health is the exclusive preserve of biomedicine, and is objective; while wellbeing is about subjective emotional and psychological states (McNaught 2011). This has caused confusion. For example, Spiegel (1998) noted how health is often mistakenly assumed to be the necessary precondition for wellbeing;

> *Thus, although good health is more than the absence of disease, disease does not imply the absence of happiness.*
>
> ***(p. 87)***

Making a similar point, Lawton-Smith (Head of Policy for the UK's Mental Health Foundation) ponders the relationship between wellbeing and *mental* health;

> *… of course, it is possible to have a mental health problem while being generally happy with life, and to be generally unhappy with life without a mental health problem.*
>
> ***(Lawton-Smith 2011, p. 4)***

So, while the term *wellbeing* is widely used in health and social care, it remains largely unexamined in its own right and poorly understood as a consequence. Significantly, perhaps, there is no consensus on how to write it: *wellbeing*, *well-being* and *well being* are all used. What follows is an exploration of wellbeing in relation to contemporary mental health practice, with an emphasis on social perspectives and an awareness of the increasing inclusion of wellbeing in mental health and social policy.

Defining Wellbeing

The coupling of wellbeing and health is now a feature of everyday language (McNaught 2011). The *Oxford English Dictionary* (2013) defines wellbeing as 'the state of being or doing well in life; happy, healthy, or prosperous condition; moral or physical welfare (of a person or community)'. It is interesting, from an occupational perspective, to note the conjunction of 'being' and 'doing' and the fact that wellbeing is considered to be both a personal and societal phenomenon. However, attempts to define and explore wellbeing more deeply – so it can be used more reliably within health and social care practice – reveal wellbeing to be a complex, confusing and contested topic. The search for a generally accepted definition of such an elastic concept has been described as 'frustrating and fruitless' (McNaught 2011, p. 10).

The International Classification of Functioning, Disability and Health has defined wellbeing as 'a general term encompassing the total universe of life domains including physical, mental and social aspects (education, employment, environment, etc.) that make up what can be called a 'good life'' (WHO 2001a). While this definition highlights wellbeing's complex nature, it also reinforces its elasticity.

In her review and critique of the use of wellbeing in the professional discourse across occupational therapy and occupational science, Aldrich (2011) noted a large discrepancy between the number of sources that used *wellbeing* (or *well being* or *wellbeing*), as a keyword and the number of sources that also provided a definition of the term. She concluded that wellbeing was widely seen as a standardized concept that needed no definition because it was universal. However, she saw no evidence to support this claim of universality. Instead, the diversity of definitions suggested that the term is used inconsistently and uncritically (Aldrich 2011). Indeed, it sometimes seems to be used as a 'linguistic flourish' (McNaught 2011, p. 8). For example, in various

contexts it has been used as a concrete noun (where wellbeing is a distinct entity that can be improved or threatened), or as an adjective or qualifier for another noun (as in 'wellbeing outcomes'). It may be seen as something specific to particular groups (as in 'children's wellbeing' or 'employees' wellbeing') or as an 'extender' to a set of other qualities, somehow bringing them together, (as in 'x, y, and wellbeing') (Ereaut and Wright 2008).

It is possible that our intuitive sense of what wellbeing *might* mean confounds our attempts to clearly articulate what it is. Ereaut and Wright (2008) argue that, as a *social construct*, wellbeing cannot have a fixed meaning;

> *It is a primary cultural judgement: just like 'what makes a good life?' it is the stuff of fundamental philosophical debate.*
>
> ***(p. 7)***

They also note that wellbeing is 'up for grabs'; being hotly contested, and accorded particular significance. For example, the UK government's mental health outcomes strategy states that 'more people of all ages and backgrounds will have better wellbeing and good mental health' (DH 2011, p. 6). Like the previous government (DH 2009), it defines wellbeing as:

> *A positive state of mind and body, feeling safe and able to cope, with a sense of connection with people, communities and the wider environment*
>
> ***(DH 2011, p. 90)***

Agreeing how to define wellbeing may create problems when, as Aldrich (2011) notes, our use of the term implies judgements and assumptions about what it *ought to be*. For occupational therapists, whose person-centredness arguably has wellbeing as the ultimate goal of intervention (Hammell 2008; Pentland and MacColl 2009), these value judgements must be consciously acknowledged if occupational therapy is to be truly person-centred, culturally sensitive and inclusive. It would therefore be advantageous for occupational therapists to be able to describe more clearly what wellbeing means *to them*. There are two strategies for stabilising meaning; overt definition, and discursive usage aiming to give a term greater currency and hence understanding (Ereaut and Wright 2008). This chapter adopts the latter approach.

WELLBEING AND MENTAL HEALTH

The WHO (2001b) has defined mental health as 'a state of wellbeing in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community'. In order to appreciate the resonance of wellbeing as a concept within mental health practice, this chapter now presents a variety of perspectives of wellbeing, concluding with specifically *occupational* perspective of it. This encompasses the different viewpoints through its holism, and offers a basis for incorporating wellbeing into occupational therapists' professional reasoning and practice. Wellbeing has historically been explored from two distinct, yet complementary traditions; a sociological viewpoint, focusing on *social* capital, and a psychological one, focusing on *mental* capital (Pilgrim 2009).

Wellbeing and Social Capital

The sociological viewpoint conceptualizes wellbeing as a relational, not a solitary, experience; one that reflects our interdependence within our family, friends and neighbourhood networks. The importance to a person's mental health of their social connectedness has long been recognized within mental health practice but it has proved to be challenging for service providers to reliably incorporate it as a resource in their care planning with individuals (Morgan and Swann 2004).

McKenzie and Harpham (2006) suggest it is difficult to draw a clear distinction between the comparatively well-researched concepts of social support and social networks, and the concept of social capital. Wilcock (2006, citing Nutbeam 1998) offers the following definitions: *social support* is the assistance available to individuals and groups from within communities that can provide a buffer against adverse life events and living conditions, and be a positive resource for enhancing quality of life; *social networks* are the relations between individuals that may provide access to, or mobilization of, social support; and *social*

capital is the degree of social cohesion which exists in communities. Putnam (1993) defines social capital as participation in community networks, the sense of belonging, solidarity and equality derived from that participation, and the norms of reciprocity and trust that emerge between co-participants. Social capital is, therefore, about people and populations 'having opportunities to participate in society and enact their rights of citizenship in everyday life' (Whiteford and Pereira 2012, p. 188). It can be seen as a process *and* an outcome; the means by which people are enabled to participate, as well as the fact of participation (Whiteford and Pereira 2012). Putnam (1993) suggests that social capital can not only strengthen the ties of people who know each other but makes for a more receptive or inclusive society, capable of bringing together people who previously did not know each other. Social capital is, therefore, a property of groups rather than of individuals, whereas social networks are a more discrete feature of individuals' day-to-day lives. Social inclusion is discussed further in Chs. 23 and 24, which focus on community settings and older people, respectively.

This sociological perspective is a broad one. Participation and inclusion are viewed against the backdrop of factors, such as social class, gender, ethnicity, place of living, health-related behaviours, and the degree of choice an individual or family has regarding education, work and play (Barry and Yuill 2012). People's innate drive to connect with others is acknowledged along with the importance of equal access to shared resources to enable people to do this. This relates to occupational justice (see Chs. 3, 13 and 29), which raises 'concerns about the unfairness of some people flourishing in what they do, whereas other people are leading unhealthy, empty, marginalized, or dangerous lives' (Stadnyk et al. 2010, p. 330). It also reflects Hammell's (2008) view that, because it is often unattainable in conditions of oppression and poverty, wellbeing is a political notion tied to human rights.

Wellbeing and Mental Capital

Mental capital refers to those elements of a person's psychological make-up that indicate how well an individual is able to contribute to society and experience a high quality of life through doing so. It is defined as:

> *the totality of an individual's cognitive and emotional resources, including their cognitive capability, flexibility and efficiency of learning, emotional intelligence (e.g. empathy and social cognition), and resilience in the face of stress.*
>
> ***(Kirkwood et al. 2008, p. 19).***

The term *mental wellbeing* describes how mental capital contributes to society. It is defined as;

> *a dynamic state in which the individual is able to develop their potential, work productively and creatively, build strong and positive relationships with others, and contribute to their community. It is enhanced when an individual is able to fulfil their personal and social goals and achieve a sense of purpose in society.*
>
> ***(Kirkwood et al. 2008, p. 19)***

This definition echoes Huber et al.'s (2011) perspective on health described earlier. The emphasis on wellbeing as something derived from doing is also significant. The psychological perspective of wellbeing places less emphasis on relationships, focusing on what is personally derived and internalized by the individual (Pilgrim 2009). Individualization and internalization finds expression in contemporary notions of positive psychology or 'happiness science' (Seligman & Csikszentmihalyi 2000). This perspective views the personal search for meaning as the impulse for self-actualization, echoing the Aristotelian principle of *eudaimonia*, or human flourishing (Carson and Gordon 2010). This is often described in terms such as belonging, resilience, hope, spirituality, self-efficacy, self-esteem, self-acceptance, flow, happiness, autonomy, purpose and meaning (see Glossary for all terms; Chs. 17 and 20 for discussion about flow; Ch. 16 for explanations of self-efficacy and self-esteem). These concepts highlight the connection between wellbeing and personal recovery (Slade and Davidson 2011). Recovery-oriented practice (discussed further in Chs. 6, 11 and 23) emphasizes these personal values. They are important because pursuing personal life goals without excessive frustration may be essential to self-efficacy, identity and wellbeing. Living within a wider society, therefore,

BOX 2-1

A SUMMARY OF SOME OF THE FACTORS THAT PROMOTE A SENSE OF WELLBEING

Contribution. An old Native American proverb states that the smile you send out returns to you. A sense of being able to give to others is an essentially healthful phenomenon.

Comfort with change in life. Self-regard and 'acceptance of one's lot' leads to being at ease in one's surroundings. Parallel with this is the ability to change and adapt so that the individual does not sink into stagnation.

Contact/companionship. Involvement and social networks are essential for human survival and the degree of support which a person perceives he or she is receiving from others is a crucial factor in the ability to cope. Empathy with others is an aspect of this.

Choice. Also significant is the degree to which the person feels in control, having a sense of empowerment and choice.

Competency. The ability to cope builds a positive self-concept, which reinforces a sense of competency. Carrying out activities proficiently promotes self-esteem.

Commitment. This brings a sense of purpose and belonging and direction in life.

(Blair et al. 2008, p. 27)

means it is the *mutual* respect for personal identity that makes these goals achievable for individuals. In this sense, wellbeing is still dependent on reciprocal, or two-way, relationships (see also Box 2-1).

From this brief overview of social capital and mental capital, it can be seen that an understanding of wellbeing requires an appreciation of human life as it is lived *in relationship* to others. It is not determined simply by factors within the intra-personal domain.

Pilgrim (2009) suggests that somewhere between these contrasting social capital and mental capital views of wellbeing lies a strong interdisciplinary consensus on the importance of *relationships*, and it is this which is of great interest in mental health. A middle position integrates subjective, internal states *and* observable measurable social conditions, related to deprivation for example. It unites personal subjective experience with broader sociological or societal issues. In other words, wellbeing can be seen wholly as something that is not simply about social experience, nor purely as a psychological state. It is not 'either/or', but both; a *psychosocial* phenomenon.

For example, the feeling of belonging that a person gets from participating in the life of their community has been termed *cognitive* social capital because it has become internalized by them. This is distinguished from *structural* social capital, which is the availability of networks and relationships in a given area. Cognitive social capital is a reliable predictor of wellbeing while structural social capital may not be; particularly if a person is living in the same street as other people but leads a separate, excluded life (McKenzie and Harpham 2006).

Promoting social inclusion could therefore be understood in terms of converting structural social capital into cognitive social capital; accessing the opportunities that are 'out there' and transforming that capital into an intrapersonal sense of belonging, which is a vital dimension of wellbeing and quality of life (Chan et al. 2005).

Supporting this process requires collaboration between mental health *services* and mainstream community agencies (Fieldhouse 2012). This brings together different stakeholders with their contrasting notions of wellbeing; some health-orientated, others orientated to citizenship (Bates 2010). A psychosocial definition of wellbeing is helpful in this context:

> *Wellbeing consists of individual components (personal, relational and collective needs) and of the synergy created by all of them together. In the absence of any one component wellbeing cannot really be achieved.*
>
> ***(Nelson and Prilleltensky 2010, p. 60)***

However, the vulnerability of a person's wellbeing to the impact of specific impairments associated with mental health problems should not be overlooked. A person may enjoy a strong sense of wellbeing most of the time, derived from well-established occupations and social networks, but this may be precarious and easily undermined by the onset of acute experiences, such as derogatory voices which may be associated with psychosis, or negative or catastrophic

thinking sometimes associated with depression and anxiety. On this basis, a person's ongoing experience of wellbeing may depend on many aspects of their life, including (at times) their use of medication to address the worst of these symptoms, giving them a platform from which to maintain their occupational and social engagement (see Ch. 23, where medication is discussed in detail).

Implications for Occupational Therapy

The multi-agency environment is a feature of contemporary mental health practice wherever institutional care has shifted to community-based care. Szaz (2010) urges mental health practitioners to regard their practice as helping service users to tackle problems with living rather than addressing the symptoms of a presumed underlying pathology. Enabling the occupations of day-to-day living is a fundamental goal of occupational therapy, but it cannot be assumed that its concepts and language are shared, understandable or acceptable to all the potential community-based partners that an occupational therapist may work with to promote community integration for service users. This is precisely where an ill-defined health-centric concept of wellbeing can cause problems. Providing a good service to *clients* may be at odds with an individual's developing sense of *citizenship* (Seebohm and Gilchrist 2008; Bates 2010). The very notion of *care* may itself be the problem when what is preferred by service users is greater access to ordinary life opportunities (Beresford et al. 2010). This underscores the importance of combining micro- (client-centred) and macro-level (community-orientated) working, and appreciating the full range of factors that contribute to a person's sense of wellbeing. Occupational therapy's in-depth appreciation of the influence of person, environment and occupation on people's abilities to act in the world supports this kind of work (Turpin and Iwama 2010). This approach is explored further in Ch. 29.

In mental health terms this means focusing on promoting individuals' personal skills and resources *and* on addressing the socioeconomic environment; acknowledging how disability, exclusion, and stigmatization operate societally (Wilcock 2006). Examples of macro-level intervention include improving housing, supporting access to education and/or training, and strengthening community networks (Hosman and Jane-Lopis 2005). This kind of work offers unique opportunities for mental health promotion through inter-sectoral, cross-cutting programmes as well as specific healthcare interventions to address mental health *problems*. It reflects occupational therapy's aspiration to empower its service users (Wilcock 2006). In these ways, occupational therapy can be a bridge between services and everyday life:

> *We are, perhaps, the sturdiest and most accessible bridge between these two worlds. Maybe being the bridge is our unique role …*
>
> ***(Hasselkus 2011, p. 136)***

Health promotion professionals concur on two points; that greater health equity (or social justice) is their overriding goal, and that the 'unjust gap' between those with the best and those with the worst health is widening (Mittelmark et al 2005). Consequently, upholding the values of social justice is essential to personal and relational wellbeing. On an individual (micro-) level, many of the people in contact with mental health services lack experience of warm and supportive relationships and the therapist can facilitate the expansion of social networks to enhance feelings of wellbeing. Some of the factors that promote a sense of wellbeing are summarized in Box 2.1.

AN OCCUPATIONAL PERSPECTIVE OF WELLBEING

Wellbeing can be seen as an essentially *occupational* phenomenon, whereby health is a resource for living rather than an end in itself; in other words, wellbeing as 'well doing' (Wilcock 2006 p. 323) or 'active living' (Hasselkus 2011 p. 87).

Wilcock (2006) suggests that *wellbeing through doing* is founded on the premise that, to enjoy health and wellbeing, people's occupations must provide meaning and purpose as well as being a context for self-esteem and socialization. Wilcock (2006) further suggests the range of a person's occupations should include physical activity, intellectual challenge, spiritual experiences, experiences of timelessness and

higher-order meaning, emotional highs and lows, solitary and social experiences, effort and relaxation. The phenomena highlighted earlier – belonging, resilience, hope, spirituality, self-efficacy, self-esteem, self-acceptance, flow, happiness, autonomy, purpose, meaning, occupational justice, social inclusion, citizenship and recovery – resonate across this range of experiences. In short, Wilcock (2006) sees wellbeing as the net result of people striving to reach their potential through what they *do*.

Interestingly, the New Economics Federation echoes and popularizes this occupational perspective by identifying ways of promoting one's wellbeing based on 'evidence from the science of wellbeing' (nef 2008), provided by the UK government's Foresight Project on mental capital and wellbeing (Kirkwood et al. 2008). Five ways are suggested: to connect socially; to be physically active; to take notice of the world around one in the moment; to keep learning and to give of oneself and one's time to one's wider community.

In addition to considering how occupation promotes wellbeing at any given point in time, occupations are also essential in maintaining wellbeing throughout the developmental stages of a person's life. Wellbeing is indicated by changes in occupational performance and engagement at transitions throughout life, and has been described as:

> *a flourishing condition that derives from a life where there is congruence among the person's occupations and their values and meaning.*
>
> ***(Pentland and MacColl 2009, p. 169)***

Hasselkus (2011) sees the embeddedness of occupation across the lifespan as the most powerful dimension of the relationship between occupation and wellbeing; more so than occupation as *therapy*. This dimension of wellbeing is a universal phenomenon across cultures and for all people. Self-actualization through occupation underpins human biological, psychological (emotional and cognitive), social, and spiritual development, and is responsible for the development of each person's unique personality and social behaviour. It is a view of the individual as a self-interpreting being. In short, individuals become defined (and define themselves) in the course of living a life (Hasselkus 2011). This echoes the idea that occupational therapists need to align their practice to the broad challenge of *enabling occupation*. Focusing on wellbeing (rather than simply health) can be a powerful stimulus to innovative practice. It can liberate practitioners from delivering occupational therapy *as it is known to be* and open up possibilities for occupational therapy *as it might become*.

In this wellbeing-focused endeavour, occupational therapy has much to offer. It is strengths-orientated, solutions-focused (as opposed to adopting an illness perspective) and person-centred (see also Ch. 23). It appreciates the contextual nature of occupation, understands the need to work at community, population, and global levels to promote occupation, and straddles health and social care in its education and practice settings. It recognizes the transformative power of occupation as a therapy and also appreciates how embedded occupation is in human wellbeing throughout the lifespan. It combines psychological, physiological, and sociological perspectives, and has developed models of practice that encompass this complexity and appreciate the human drive to flourish.

Summarizing these characteristics underlines how they cohere as one single, holistic professional perspective; one that offers a multifaceted approach to understanding and promoting wellbeing. In this way, an argument builds for an occupational perspective of wellbeing and the contribution of occupational therapy to the wellbeing agenda. However, it is unclear how occupational therapy, as a profession, will consider its role, and how its potential contribution might be presented in wider social and political arenas:

> *Occupational therapy is said to be based on the belief that there exists a universal and fundamental relationship between people's dignified and meaningful participation in daily life and their experience of health, wellbeing, and quality of life. However, who decides what occupations are dignified and meaningful is not only culturally informed but is also probably politically negotiated. It requires occupational therapists to view enabling access to meaningful occupation as a right, not just 'treatment' but a political endeavour.*
>
> ***(Pollard et al. 2009, p. 3)***

WELLBEING AS A POLITICAL PRIORITY

The world recession of 2008 highlighted the need for measures of progress beyond the economic. Many developed countries have now had almost continuous rises in average incomes for over 150 years but are seeing that additional wealth is not as beneficial to individuals' wellbeing as it once was (Wilkinson and Pickett 2010). Indeed, economic growth in market democracies across the world has been accompanied by increased rates of depression, suicide, addictions, family breakdown, and interpersonal violence (Carlisle et al. 2010). Beyond a certain level of affluence, increasing prosperity counts for less and less. The relationship between good health and prosperity levels off and weakens after the early stages of economic growth, and the same is true of happiness (Wilkinson and Pickett 2010);

> *This is a predictable pattern. As you get more and more of anything, each addition of what you have – whether loaves of bread or cars – contributes less to your wellbeing.*
>
> ***(p. 8)***

Despite (or maybe because of) the lack of clarity about what wellbeing means, it features prominently as a declared political priority in much of the developed world as an alternative to the historical goal of economic prosperity (Pilgrim 2009). Even when wellbeing is presented in this way, it is done with no explicit definition (McNaught 2011). For example, the UK government's definition (see earlier) states that wellbeing is a 'positive' state and an 'important' part of health (DH 2011). The very vagueness surrounding wellbeing is perhaps what makes this expedient as a rallying-call, in political terms. It is hard to hold politicians accountable when indicators of wellbeing are unformulated and ambiguous.

Nevertheless, the health implications of inequality are striking. Social inequality is conducive to poor health and wellbeing outcomes for entire populations, not just for the poor and disadvantaged in a society (Wilkinson and Pickett 2010). It is widely acknowledged that societies with the biggest gaps between rich and poor are damaging for everyone in them, including the well-off. Moreover, while greater social equality yields the greatest benefits for the poor, the benefits of equality are seen to extend to the majority of the population too (McNaught 2011).

Social justice has implications for the incidence of mental health problems in particular. There is a relationship between common mental health problems and a poor standard of living (Lewis et al. 2011) and a much higher percentage of the population experience mental health problems in more unequal countries; particularly from anxiety disorders, impulse-control disorders, and severe mental health problems (Wilkinson and Pickett 2010). As described, a broad range of factors influence wellbeing. Bio-medical health is but one component and modern conceptualizations of wellbeing acknowledge that it cannot be developed appropriately by health agencies acting alone. The wellbeing agenda is necessarily a cross-cutting one. For example, in the UK, Health and Wellbeing Boards were established under the Health and Social Care Act (DH 2012) to bring leaders from the health and care system together to improve the health and wellbeing of their local population through integrated services. The UK Government also plans to introduce questions about subjective wellbeing into the next UK national census in 2021 (Knight and McNaught 2011).

There is a paradox here, however. Although the World Health Organization (WHO 2001a) described wellbeing in terms of a good life it is clear that unilateral striving for the 'good life' – as manifested in the economics, individualism, materialism, and consumerism of post-industrial Western society – is increasingly recognized as being ultimately pathological for people's wellbeing (Eckersley 2000). From this perspective individuals' wellbeing can more accurately be seen as a reflection of a 'successful society' (see below); one where economic activity produces high, sustained levels of wellbeing for all citizens, without placing unsustainable pressure on environmental resources (nef 2013).

On this basis, the notion of gross national happiness is an emerging perspective. This concept is gaining credence as an attempt to find an indicator that measures quality of life more holistically than the conventional method of assessing gross domestic product (the value of goods and services produced in a country in a year), on the basis that most people aim to be happy and

healthy, rather than wealthy (McNaught 2011). The Happy Planet Index (Abdallah et al. 2009) was introduced as a socioecological measure indicating the environmental efficiency of supporting wellbeing in a given country using life satisfaction data, life expectancy and ecological footprint. In short, it measures 'happy years of life per unit of resources consumed' (Carlisle et al. 2010) and highlights how much of the planet's natural resources it costs to sustain a country's lifestyle. Rich developed nations fall somewhere in the middle. It has been suggested that, considered in this way, wellbeing can be a reflection of personal, societal, national and global connectedness (Nelson and Prilleltensky 2010). In other words, it highlights how our personal, individual occupations impact on, and are impacted upon by, societal and global patterns of occupation.

A 'Successful Society'

Societal wellbeing refers to both the collective wellbeing of individuals and the quality of interactions between and among individuals and social institutions (such as communities, the labour market, the healthcare system, the education system and the social security system). Furthermore, self-determination is based on opportunities and resources within the community which is inhabited by everyone, so collective values complement individual and relational ones. In the UK, Skilton (2009) defined societal wellbeing as a positive social and mental state requiring that basic needs are met, that individuals have a sense of purpose, and that they feel they can achieve important personal goals and participate in society. It is enhanced by supportive personal relationships, empowered communities, good health, financial security, rewarding employment and a healthy and attractive environment.

The Political Imperative of an Occupational Perspective of Wellbeing

Occupational therapy's capacity to engage with and develop concepts of wellbeing (both theoretically and practically) highlights the political dimensions of occupational science and presents occupational therapy as a political practice (Pollard et al. 2009).

Given that wellbeing is a broader concept than bio-medical health, that a national and international wellbeing agenda exists, and that the political will to address inequality is subject to the vagaries and expediencies of party politics, a question arises: *Where does the expertise for promoting wellbeing lie within health and social care*? If occupational therapy's contribution to a national wellbeing agenda is to truly reflect its macro-level health promotion perspective (as indicated in the earlier discussion), it would require occupational therapists to think and act politically (Wilcock 2006). This is a significant challenge. It is hoped, by exploring some of the concepts and terminology with which wellbeing is being discussed and developed outside occupational therapy, that this chapter will highlight connections with occupational therapy's own constructs and practices. In this way, occupational therapists will be able to continue to develop their work as enablers of occupation, appreciate fully the connection with being enablers of wellbeing, and feel better equipped to do so with a wider range of inter-professional and inter-agency partners.

Other professional groups have seen the wellbeing agenda as an opportunity for their own advancement. For example, mental capital and wellbeing has been investigated by psychologists and psychiatrists on behalf of the UK Government in the Foresight Project, described earlier (Kirkwood et al. 2008). However, Pilgrim (2009) notes how the wellbeing *agenda*, and the opportunity for professional advancement it affords some, may work against its own aims. Not only does professional self-promotion undermine inter-professional collaboration (which is in service users' interests) but it could result in an over-exclusive emphasis on individuals and their 'treatment' coming to shape the wellbeing agenda. In short, it misses the bigger picture that the social model of disability can reveal:

> *if we are to gain further improvements in the real quality of life, we need to shift attention from material standards and economic growth to ways of improving the psychological and social wellbeing of whole societies. However, as soon as anything psychological is mentioned, discussion tends to focus almost exclusively on individual remedies and treatments. Political thinking seems to run into the sand.*
>
> *(Wilkinson and Pickett 2010, p. 4)*

MEASURING WELLBEING

If wellbeing is a goal and outcome of occupational therapy, then measuring it becomes an important professional consideration. Ch. 5 is about assessment and outcome measurement and explains the importance of measuring outcomes more fully.

While it is acknowledged that the term wellbeing is used inconsistently and uncritically, there is general acceptance that it is shaped by a wide range of factors (Carlisle et al. 2009). Consequently, any attempt to measure wellbeing must recognize this complexity (Jones-Devitt 2011). However, this can create difficulties when selecting an appropriate measurement tool.

There are several measures of wellbeing in existence; some of which are presented in Box 2-2, as examples. This is not an exhaustive list and inclusion in the list does not indicate endorsement of the measure by the authors. The diverse ways in which the term wellbeing is used across the measures in Box 2-2 reflect some of the linguistic issues highlighted earlier in the chapter. For example, the term wellbeing may be no more than a linguistic flourish if the phenomena linked together by Stride et al (2007) (job satisfaction, organizational committment, and mental health) are not justifiably shown to be components of 'job-related wellbeing'. Similarly, the KIDSCREEN-10 score is described as a measure of children and adolescents' wellbeing and health-related quality of life (Ravens-Sieberer et al. 2010), yet there is no examination of, nor certainty that, wellbeing and health-related quality life are comparable phenomena.

BOX 2-2

A LIST OF OUTCOME MEASURES OF WELLBEING INDICATING THE RANGE OF MEASURES AVAILABLE

- Body-Mind-Spirit Well-Being Inventory (Ng et al. 2005)
- BBC Wellbeing Scale (Kinderman et al. 2011)
- General Psychological Wellbeing Scale (Khumalo et al. 2010)
- KIDSCREEN-10 score (Ravens-Sieberer et al. 2010)
- Subjective Wellbeing under Neuroleptic Treatment scale (Naber et al. 1994)
- Measures of job satisfaction, organizational commitment, mental health and job-related wellbeing (Stride et al. 2007)

Proxy Measurement of Wellbeing

Acknowledging its complex nature, wellbeing can also be measured using a proxy measure or by an assessment battery. A proxy measure may be used to 'get at' a healthcare phenomenon which is elusive or very complex. One might see it as allowing practitioners to use a process measure instead of an outcome measure, perhaps; that is, accessing a measurable process in place of a phenomenon that is harder to access or identify;

> *Using a proxy measure means when you can't measure exactly what you want/need, you measure what you can*
>
> ***(Department of Community and Family Medicine 2005).***

The Beck Depression Inventory, for example, has been assessed as a proxy measure of subjective wellbeing (Van Hemert et al 2002) and dementia care mapping (See Ch 24 on older people) has been assessed as a proxy measure of the wellbeing of people with dementia (Innes and Surr 2001). In terms of using an assessment battery (a number of measures), Hayes et al. (2010) conducted a study to identify a range of measures to measure the wellbeing of spouses assisting with veterans' recovery, and Smith and Brun (2006) conducted a review to identify a range of measures to measure children's wellbeing.

However, it is not possible to identify a universally accepted measure of wellbeing, nor a widely accepted strategy for measuring wellbeing generally or in occupational therapy specifically (Aldrich 2011). This means great care needs to be taken in selecting measures of wellbeing. To select a measure one needs to be clear about how wellbeing is conceptualized (Aldrich 2011). It is hoped that this chapter will be a useful guide to practitioners and researchers in this respect. Once conceptualization is clear, a search strategy must be developed to identify a measure of wellbeing that exhibits these properties. Any measure selected needs to be evaluated to assess its psychometric properties; that is, its reliability, validity and utility (see Ch. 5 for more details).

CONCLUSION

Occupational therapy's contribution to understandings of wellbeing has been considered, recognizing how wellbeing is multifaceted and may be approached from philosophical, social, clinical and economic perspectives. Drawing on contemporary conceptualizations of wellbeing, the key components have been highlighted. The challenges associated with measuring wellbeing have been presented and an indication has been given of the range of measures available. The national and international wellbeing agenda has been presented as a cross-cutting political agenda that occupational therapy and occupational science can speak clearly to.

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