

Chapter 2

Occupational perspectives on mental health and well-being

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INTRODUCTION

The beginning of the 21st century is characterised by an increased interest in the prevention of mental ill health and the promotion of well-being. All professions involved in health and social care have explored ways of broadening their remit, perhaps encouraged by the shift of working contexts in the United Kingdom, which are now largely community based. The World Health Organization (WHO) (2001) has more formally linked ideas of activity and participation within the *International Classification of Functioning, Disability and Health*. In Scotland, a link between policy and services is apparent, for example in the *National Programme Action Plan 2003–2006 to improve mental health and wellbeing in Scotland* (2001). In turn, this is part of a broader Scottish Executive policy initiative that includes attention to health improvement, social justice, education and lifelong learning.

Until recently, the responsibility for health promotion lay within the field of public health. Now, more attention is being given to health promotion within health-care policies; for example, *The Health of the Nation* (DoH 1992), *Saving Lives* (DoH 1999) and the *National Programme for Improving Mental Health and Well-Being* (Scottish Executive 2003). These policies give priorities for action, such as dementia awareness; suicide reduction; eliminating stigma and discrimination in minority ethnic groups, and the mental health of children and young people. Policies designed to integrate spirituality into health care, together with other

publications such as *Caring for the Spirit* (South Yorkshire Workforce Development Confederation 2003), have led to changes in education for staff that broaden the focus of health promotion and health education.

These policy initiatives have implications for occupational therapists throughout the UK and Creek (2004) predicted that the profession will continue to have a much higher profile within health promotion. Those occupational therapists who have accepted the challenge of exploring the relationship between occupation and health, and of working towards occupation-centred practice, are finding this an exciting time. The discipline of occupational science has boosted knowledge generation in this area and the ideas of people as occupational beings, whose complex actions and interactions significantly impact on health, have stimulated the enthusiasm of students, educators, practitioners and researchers (Wilcock 1998). Occupational science has also encouraged a broader vision of the contribution of occupation to social justice, with the notion of occupational justice (Wilcock & Townsend 2000).

This chapter begins with an exploration of the terminology used to refer to mental health, mental disorder and the promotion of positive mental health. There is then a discussion of the personal characteristics, events and experiences that have been found to promote or inhibit positive mental health: protective factors and risk factors. The third section describes strategies and interventions used to promote positive mental health in individuals and communities. It concludes with some thoughts on the role of occupational therapy in promoting mental health and well-being.

UNDERSTANDING THE TERMINOLOGY

There are many terms used in the field of health promotion and disease prevention, each one given a variety of different meanings. These key terms can be found in published papers and glossaries, and are frequently heard in occupational therapy seminars and conferences. It is particularly interesting to note that language usage by occupational therapists has changed over the

past decade from a preponderance of medical terminology to a more client-centred and occupation-focused style. The concepts defined here are health, mental health, well-being, health promotion, disease prevention, health education, mental health promotion, wellness, lifestyle and quality of life.

HEALTH

Defining health is a complex matter and the concept defies neat description. The occupational scientist, Wilcock (1998), offered an occupational perspective on health in which she explored the relationship between occupation and health and the importance of this relationship for public health. Wilcock acknowledged the enduring nature of the WHO (1946) definition of health: 'Health is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity'.

However, there have been many criticisms of this definition; for example, Webb (1994) noted that it implies a static rather than a dynamic phenomenon. In contrast, the moral philosopher David Seedhouse (1986, p61) offered a definition that acknowledges the dynamic nature of health and recognises individual differences:

A person's optimum state of health is equivalent to the state of the set of conditions which fulfil or enable a person to work to fulfil his or her realistic chosen and biological potentials. Some of these conditions are of the highest importance for all people. Others are variable dependent upon individual abilities and circumstances.

The WHO has been moving towards an understanding of the dynamic relationship between what people do and their health. The *Ottawa Charter for Health Promotion* (WHO 1986, p1) stated that health is 'a resource for everyday life, not the objective of living ... it is a positive concept emphasizing social and personal resources, as well as physical capacities'. The *International Classification of Functioning, Disability and Health* (WHO 2001) has a focus on activity and participation that locates occupation as a major domain within health.

MENTAL HEALTH

The concept of mental health can be problematic, not least because it may be understood very differently in different cultural contexts (Fernando 1993). Indeed, it has been said that 'every definition of mental health has inherent cultural assumptions' (Chwedorowicz 1992, cited by Tudor 1996, p22), which means that no one definition will be appropriate for all purposes.

Mental health can be defined as the absence of objectively diagnosable disease – a deficit model – or as a state of physical, social and mental well-being – a positive model (mentality 2004). Current definitions of mental health usually incorporate both personal characteristics and the influence of environmental and social conditions. In other words, mental health is an interaction between the individual and her or his circumstances.

The Health Education Authority (1997) defined mental health as: 'the emotional and spiritual resilience which enables us to survive pain, disappointment and sadness. It is a fundamental belief in our own and others' dignity and worth'. The Scottish Public Mental Health Alliance (2002, p4) suggested that positive mental health is a resource that strengthens the ability to cope with life situations. It went on to say that the 'core individual attributes of positive mental health include the ability to:

- develop self-esteem/sense of personal worth
- learn to communicate
- express emotions and beliefs
- form and maintain healthy relationships
- and develop empathy for others'.

Being mentally healthy implies having the ability to cope with changes and life transitions, adapt to circumstances, set realistic aims, reach personal goals and achieve life satisfaction. In contrast, mental health problems disrupt people's capacity to think and feel in a way that is normal for them, interfere with the ability to make decisions and shatter people's sense of well-being.

WELL-BEING

The state of well-being, like health, is a multifaceted phenomenon. The *Oxford English Dictionary* (Brown 1993) definition links it with both health

and welfare: 'healthy, contented or prosperous condition; moral or physical welfare'. An Australian occupational therapist, Therese Schmid (2005, p7), emphasised that the state of well-being is a subjective experience consisting of: 'feelings of pleasure, or various feelings of happiness, health and comfort, which can differ from person to person'. Wilcock (2006, p36) agreed that 'Health, happiness and prosperity have more than an intuitive fit with well-being'.

The American occupational therapist Betty Hasselkus (2002, p60) wrote that 'Research on the human state of well-being is permeated by the belief that a person's ability to engage in life's daily activities is a key ingredient'. She referred to the work of two psychologists, Ryff & Singer (1998, cited by Hasselkuss 2002, p61), who suggested that well-being can be defined by two core features: '1) leading a life of purpose, and 2) quality connections to others'. This description is reminiscent of Winnicott's idea of reciprocity as a necessary precursor to well-being.

The psychotherapist Donald Winnicott is reputed to have pronounced that 'health was more difficult to deal with than disease' (Phillips 1989, p612). Certainly, changes have to be made in attitude, ideology and delivery of practice to accommodate the values of client education and enablement, which are central to the promotion of health. For over 40 years, Winnicott's work charted influences on personal growth and development, and one of his key themes was the metaphor of a containing space or holding environment as a necessary precursor to health and well-being. For him, health was concerned with nurturing relationships and reciprocity. Occupation tends to engage people in mutual endeavour where such reciprocal relationships can develop and, therefore, offers real possibilities for the promotion of healthy individuals and of healthy communities where people can live and learn together.

HEALTH PROMOTION

Since the mid-1980s, a confusing array of terms has been used in this area, including health promotion, health education, disease prevention and health protection. For example, Downie and colleagues (1993, p59) defined health promotion

as ‘effort to enhance positive health and prevent ill-health, through the overlapping spheres of health education, prevention and health protection’. They emphasised that the health promotion approach involves a sense of individual control.

Seedhouse (1997, p61) also defined health promotion in terms of effort, and helpfully attempted to unpick some of the terms used within his definition:

Health promotion comprises efforts to enhance ways of acting and believing based on conservative political values and to prevent disease and illness, through a co-ordinated plan to influence individual behaviour in specific ways (health education), providing and strongly promoting the uptake of medical surveillance (disease prevention), and by legislating to guarantee or firmly enforce some behaviours in order to reduce some morbidities (health protection).

The WHO (1986, p1) definition is useful for occupational therapists because it views health promotion as a process of enablement: ‘Health promotion is the process of enabling people to increase control over, and to improve, their health’.

DISEASE PREVENTION

The prevention of mental disorders, or the prevention of relapse, is often seen as one of the aims of mental health promotion strategies (WHO 2002). The WHO (2002) pointed out that the idea of primary disease prevention as a way of preventing disease from developing does not work well in the field of mental health, where it can be difficult to determine the exact time of onset or even to agree on a definite diagnosis. Rather, the *primary prevention* of mental disorders involves interventions at three levels.

- *Universal prevention* targeting a whole population group; for example, advertising on television the safe limits of alcohol consumption.
- *Selective prevention* targeting subgroups at high risk; for example, providing free nursery places for the children of single parents.
- *Indicated prevention* targeting individuals at high risk; for example, offering counselling to the children of mothers with depression.

Secondary prevention refers to all treatment-related strategies designed to reduce the prevalence of mental disorder, and *tertiary prevention* refers to interventions that reduce disability, mitigate the severity of disease, prevent relapse or contribute to rehabilitation and recovery.

HEALTH EDUCATION

All health-care professionals have a responsibility in terms of health education, which has been described by Downie and colleagues (1993, p28) as ‘communication activity aimed at enhancing positive health and preventing or diminishing ill-health in individuals and groups, through influencing beliefs, attitudes and behaviour of those with power and of the community at large’. Health education can also be targeted at different levels (Draper et al 1980).

1. Health education about the body and its maintenance, for example at school.
2. Health education involving information about access to and appropriate use of health services, such as radio advertisements about sexual health advice lines.
3. Health education within a wider context that includes education about national, regional and local politics that have ramifications for health.

MENTAL HEALTH PROMOTION

Interest in the promotion of mental health has a history of more than 100 years, dating back to the formation of the Finnish Association for Mental Health in 1897. The World Federation of Mental Health was founded in 1948 to promote better understanding of mental illness and to serve as a means of drawing attention to mental health. More recently, an initiative between the European Commission and the WHO (WHO 1999) acknowledged that issues surrounding mental health problems contribute to five of the 10 leading causes of disability worldwide and that, while ongoing improvements in physical health can be detected, this is not the case for mental health.

Mental health promotion is about ‘improving quality of life and potential for health rather than

the amelioration of symptoms and deficits' (WHO 2002, p8). It consists of actions taken to enhance the mental well-being of individuals, families, organisations and communities (mentality 2004).

There are several complementary models of mental health promotion which acknowledge both individual and broader socio-economic determinants of mental health. A common feature of these models is recognition of the need to broaden mental health promotion programmes and interventions beyond those targeting the individual. For example, community interventions that focus on building social capital or policy-level interventions which widen participation in education have also been identified as mental health promotion.

A public mental health approach, that supports the enhancement of well-being or the promotion of positive mental health, reflects a public health ethos which looks beyond individuals to the physical, social and environmental context for health (DoH 2001). The logical endpoint of this approach is the design and delivery of interventions and programmes to promote the mental health of organisations and communities with a view to fostering a mentally healthy society.

WELLNESS

In 1986, an American occupational therapist, Jerry Johnson, wrote a book about wellness, which she described as 'a context for living' (Johnson 1986, p13). By this, she meant that wellness is a process of caring for oneself, including care for the body, the emotions, personal identity and the spiritual self.

The WHO definition of wellness includes both individual characteristics and social integration:

Wellness is the optimal state of health of individuals and groups. There are two focal concerns: the realization of the fullest potential of an individual physically, psychologically, socially, spiritually and economically, and the fulfilment of one's role expectations in the family, community, place of worship, workplace and other settings. (Smith et al 2006, p344)

Wellness requires that a harmony is sought between mind, body and spirit and also between the individual and society. Occupational therapists

would also suggest that a balance of occupations contributes to a state of wellness.

LIFESTYLE

Lifestyle has been defined as 'the particular way of life of a person or group' but the term is often used to refer to 'health-related behaviour such as smoking, drinking, diet and exercise' (Ewles & Simnett 2003, p337). Occupational therapists think more broadly about lifestyle as being the configuration of an individual's activities that links with both personal needs and the expectations of society. For example, Mayers (2003) designed a lifestyle questionnaire that covers self-care, living situation, looking after others, being with others, work or education, beliefs and values, choices, finances and desired activities.

QUALITY OF LIFE

It is difficult to agree on what constitutes quality of life, since it can mean different things to different people. Mayers (1995) searched the literature and found that, while the concept of quality of life was widely used, there were few attempts to define it. Common features of existing definitions included subjective satisfaction, choice, sense of well-being, fulfilment of hopes and spiritual satisfaction. Mayers (2000) suggested that quality of life is concerned with both the satisfaction of needs and the ability to meet personal priorities.

Since quality of life is a subjective experience, it should be measured using self-completed questionnaires or rating scales (Mayers 1995).

FACTORS CONTRIBUTING TO MENTAL HEALTH AND ILL HEALTH

Many factors have been found to influence the mental health of individuals and communities, including both individual coping mechanisms and social support. These factors can be divided into three categories: biological, psychological and sociological/environmental. Some examples of each are given in Box 2.1.

Box 2.1 Factors that may affect mental health**BIOLOGICAL**

Biochemical
Cerebrovascular accident
Trauma, e.g. head injury
Genetic
Toxins, e.g. alcohol
Deafness
Physical ill health
Pollution
Nuclear contamination

PSYCHOLOGICAL

Stressful life events
Learned behaviour
Relationships
- expressed emotion
- double bind
Loss
Loneliness
Abuse
Experience of being a
refugee

SOCIOLOGICAL/ENVIRONMENTAL

Deprivation and poverty, including
homelessness
Social status
Unemployment
Gender/sexual orientation
Racism
Vandalism
Migration
Climate
Noise
Natural disasters
Terrorism

The rapid pace of change in modern society, along with increased geographical and social mobility, is putting stress on people while weakening supportive social structures, such as the extended family. When the normal balance of life is disturbed by external or internal factors, the relationship between stress and the ability to cope with the demands of everyday life can be depicted in the form of a curve, in which performance increases while the individual is in a state of ever-heightening arousal. This arousal prevents attention to the warning signs of fatigue, culminating in physical or psychological ill health. A model of how interacting demands can contribute to illness is shown in Figure 2.1.

Across the lifespan, everyone experiences a range of transitions such as leaving home, starting work, marrying or retiring. These transitions will be challenging but are regarded as normal stages within development (see Box 2.2). People in general have considerable capacity to withstand the stresses of transitions and other traumatic events. Many years ago, Holmes & Rahe (1975) identified life events which were significant and rated these according to the stress which they provoke. Events relating to loss, such as bereavements, unemployment and ill health, are examples of significant crisis situations. However, more positive events such as the formation of partnerships are not without stress!

Unexpected life events and normal transitions, such as those shown in Box 2.2, have important implications for health and well-being. How individuals manage such events depends upon

a complex mix of personal, social and economic factors. The robustness of personality plus sound support systems usually enable people to negotiate transitions, but anxiety and depression can result from major life cycle changes such as marriage, parenthood, unemployment, retirement or loss.

Occupational therapists are interested in the ways in which occupations change over the course of the lifespan and correspond to life events. A sense of continuity is an important element in understanding an individual's strengths and coping capacity when faced with transitions in life. Kaplan & Sadock (1991), in a general text on psychiatry, included a section on 'phase of life problem'. It is recognised that stresses in the life cycle, due to life changes and transitions, can be key aspects of a presenting problem.

The context in which life events occur is obviously of importance – the widower with young children who is made redundant will not experience the same reactions as the older man with a grown-up family. Perceived support is one of the key factors in ability to cope when life events threaten a person's sense of well-being. One person's stress is another person's motivation to continue and many people operate at high stress levels, producing excellent work.

Stress is a process in which perceived demands (internal or external) severely tax or exceed available coping resources. This leads to a vicious cycle in which mood (depression) influences feelings

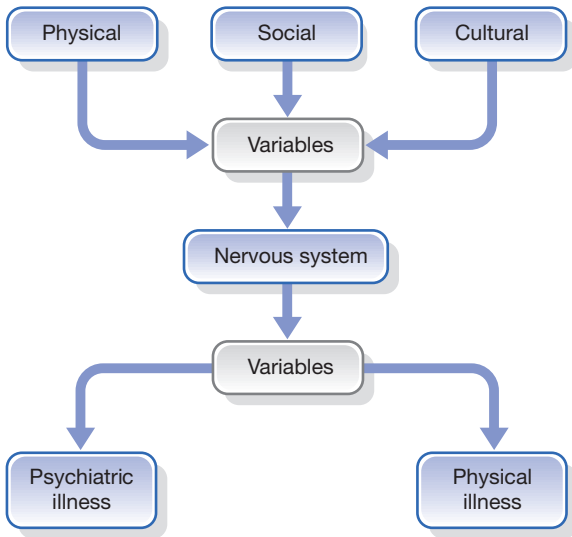


Figure 2.1 Factors Contributing to illness.

(‘I am useless’) and tends to alter behaviour (not participating in activities) which, in turn, increases the level of depression. External events are more likely to conquer someone’s adaptive ability if:

- they are unexpected
- the events are numerous
- the resulting stress is chronic and unremitting
- one loss triggers many other necessary adjustments.

Those people who are able to engage successfully with the conditions that life presents to them, including adverse circumstances and stressful

events, are called *emotionally resilient*. Emotional resilience is the name given to the range of protective mechanisms and processes that enable people to withstand the potentially damaging effects of stress and to maintain high self-esteem and self-efficacy in the face of adversity (Rutter 1987).

PROTECTIVE FACTORS

Factors that have been found to protect against the damaging effects of stress and adversity fall into four main groups: individual factors, family factors, life experiences and community factors.

- **Individual factors (including personal characteristics).** The individual with an easy temperament is more likely to have harmonious interactions with others, and this has been shown to contribute to resilience. An easy temperament is characterised by equitable mood, mild-to-moderate intensity of emotional reactions, malleability, predictable behaviour, openness to new situations and a sense of humour (Rutter 1987). Other personal characteristics that protect against the damaging effects of stress include above-average intelligence or an aptitude for a particular skill, good problem-solving skills, an internal locus of control, effective social skills, optimism, moral beliefs and high self-esteem. People who are more active, physically and/or mentally, are also more likely to be emotionally resilient. Other factors include personal awareness of strengths and limitations, a belief that one’s own efforts can make a difference and an ability to empathise with others (Newman 2002). Additional individual factors in childhood include attachment to the family, adequate nutrition and school achievement (DoH 2001).
- **Family factors.** Families that promote positive mental health are secure, stable and harmonious. They also tend to be small, with more than 2 years’ age difference between siblings. Other protective factors within the family include strong family norms and morality and at least one supportive, caring parent or a supportive relationship with another adult during childhood (DoH 2001). Where there is parental disharmony, a close relationship with one or other parent is a

Box 2.2 Transitions and life events

POSSIBLE CRITICAL TRANSITION POINTS

Birth
Adolescence
Marriage/partnership
Pregnancy
Separation/divorce
Unemployment/retirement
Dying

UNANTICIPATED LIFE EVENTS

Accidents
Life-threatening disorders
Natural disasters
Wars
Physical/mental illness
Loss of status/prestigious role
Bereavement

protective factor. A supportive extended family and a valued role for the child within the family, such as doing household chores, are further protective factors (Newman 2002).

- **Life experiences.** Three types of experience have been shown to increase the chances that a person will grow up with feelings of high self-esteem and self-efficacy. The first is secure early attachments to parents or parental figures. The second is successful task accomplishment. This can include academic success, taking positions of responsibility, social success, employment and success in non-academic pursuits such as sports or music. There is evidence that feelings of self-esteem and self-efficacy, while initially formed in early childhood, can be modified by later life experiences (Rutter 1987). The third type of experience is opportunities at critical turning points in life, when doors to new, positive experiences are opened.
- **Community factors.** Positive mental health is promoted by a sense of connectedness with the community and attachment to community networks. This may be through participation in a particular community group, such as a faith group. Healthy communities have a strong cultural identity and pride, and there are strong norms against violence (DoH 2001).

RISK FACTORS

Factors that inhibit positive mental health are called risk factors. These can be divided into the same four categories as protective factors: individual factors, family factors, life experiences and community factors (DoH 2001).

- **Individual risk factors.** These include prenatal brain damage or birth injury, prematurity, low birth weight, poor health in infancy, physical or intellectual disability, low intelligence, a difficult temperament, impulsivity, poor social skills and low self-esteem.
- **Family and social risk factors.** These include having a teenage mother and/or a single parent, absence of father in childhood, large family size, antisocial role models, family disharmony and violence, poor supervision

and monitoring of the child, long-term parental unemployment, parental mental disorder and/or criminality, a harsh or inconsistent disciplinary style, social isolation and lack of warmth and affection.

- **Life events and situations.** The factors that create risk include physical, sexual and emotional abuse, divorce and family break-up, death of a family member, poverty or economic insecurity, school transitions and war or natural disaster.
- **Community risk factors.** These include socioeconomic disadvantage, social or cultural discrimination, social isolation, neighbourhood crime and violence, poor housing and lack of community facilities such as transport, shops and recreation centres.

Mental health promotion strategies may be targeted at any or all of these areas. It has been shown that prevention and early intervention are far more effective for mental health than treating illness once it has become established.

PROMOTING POSITIVE MENTAL HEALTH

Over the last 50 years, traditional Western health care has been challenged many times in terms of its ideology, management and interventions. Dissatisfaction with the medicalisation of health has promoted new philosophies which, since the mid-1980s, have placed health care in the context of the community. Consequently, the challenge for all health-care professionals has become a quest for more proactive approaches to promote and maintain sound physical and mental health for people within their communities. Inherent in the new philosophies of care are ideas of individual responsibility, self-determination, empowerment and a more equitable partnership between client and health professional.

In 1986, the first International Conference on Health Promotion was held in Ottawa, primarily to acknowledge changing worldwide expectations for a new emphasis in the public health movement. The Ottawa Charter was the outcome of this and it endorsed the need to work towards

healthy communities and a reorientation of health services, including changes in health research and in professional education. In the same year, the Division of Health Psychology of the British Psychological Society was established, again with a focus on health rather than on illness and a drive towards a psychology of prevention rather than treatment (Niven 1989).

Health education also shifted in emphasis away from the traditional imparting of sensible information, which had been criticised for its assumption that people are rational human beings who are free to choose health-related lifestyles. Health education has become part of a broader approach to promoting health which incorporates efforts to change political, social and economic conditions for individual groups and communities. This implies co-operation between agencies in both the statutory and voluntary sectors.

Mental health promotion functions at different but interconnected levels (DoH 2001, Health Education Authority 1997).

- **Level of the individual:** increasing emotional resilience through interventions designed to promote self-esteem, life skills and coping skills, for example communicating, negotiating, relationship skills and parenting skills. This is the level with which occupational therapists are most familiar.
- **Level of the community:** increasing social support, social inclusion and participation, improving neighbourhood environments, anti-bullying strategies at school, workplace health, community safety, childcare and self-help networks. Occupational therapists are increasingly moving into this area of work.
- **Structural/policy level:** developing initiatives to reduce discrimination and inequalities and to promote access to education, meaningful employment, affordable housing, health, social and other services which support those who are vulnerable. Occupational therapists are not yet working at this level, except in isolated projects.

Strategies for promoting mental health operate through one or more of four processes (Newman 2002).

- **Altering perceptions of or exposure to risk.** For example, poor social skills are a risk factor so social skills training programmes can promote positive mental health.
- **Reducing the chain reaction that takes place when risk factors compound each other and multiply.** For example, many young people who drop out of school come from unstable families, have literacy and numeracy problems, are involved with the police, take drugs, engage in risky sexual behaviour and so on. A 10-week programme for these young people was designed to teach them basic social and personal skills in order to reduce or remove some of these risk factors.
- **Improving self-esteem and self-efficacy.** For example, a drop-in creative activity group was provided in a community centre on a large housing estate. Participants gained in self-confidence and self-esteem through making items that they valued and that were admired by friends and family.
- **Creating opportunities for change.** For example, a supported employment scheme can assist someone with limited work experience to retain a job while learning the necessary skills.

Some mental health promotion strategies have been found to be more effective than others. A review of the literature identified eight features that are characteristic of the most effective programmes (Sure Start 2004).

- **Comprehensiveness:** no single type of intervention has been found to prevent multiple high-risk behaviour, so successful programmes involve a combination of intervention methods and aim to influence a combination of several risk or protective factors.
- **System orientation:** successful interventions aim to change institutions as well as individuals, and involve the social network of the individual or group.
- **Relatively high intensity and long duration:** short-term programmes tend to have time-limited benefits, especially with high-risk groups. Long programmes (years rather than months) have an impact on more risk factors and have more lasting effects. The most

successful programmes intervene at a range of different times rather than once only.

- **Structured curriculum:** successful interventions are targeted at risk and protective factors rather than at problem behaviours.
- **Early commencement:** this is essential. Intervention during pregnancy brings additional benefits.
- **Specific to particular risk factors:** prevention needs to be disorder, context and objective specific. Generic prevention programmes have less impact.
- **Specific training:** there is no evidence about what qualifications are needed for effective mental health promotion. All people who work with young children and their carers should have skills in this area.
- **Attention to maintaining attendance:** the people who most need intervention are likely to be those who need most support if they are to stay in a programme.

OCCUPATIONAL THERAPY AND HEALTH PROMOTION

Christiansen & Baum (1997, p600) defined occupational therapy as 'a health discipline concerned with enabling function and well-being' and Brown (1987) considered that occupational therapy was an 'unrecognised forerunner in the wellness movement'. While few occupational therapists in the UK work comprehensively with the well population, they have been involved in working with carers, offering support, advice and education, for many years.

The values underpinning the promotion of sound mental health have always been implicit within occupational therapy and they have become more explicit since the renaissance of occupation as a core construct within research, theory and practice. Some of the assumptions made by occupational therapists about the relationship between occupation and health are as follows.

- People are occupational beings.
- Engagement in occupation is healthy.
- People need a healthy balance of occupation.
- There are links with purpose and meaning.

- Occupation is a tool for healthy participation in life.
- Occupation can act as a barometer for gauging health.

An understanding of the value of activity is central to the profession's philosophy and its focus on occupational performance. The health-promoting value of purposeful participation in activity is inherent in the concept of self-actualisation: through *doing*, people are confronted with the evidence of their ability to function competently and take control of their lives as far as they are able. Personal dignity and beliefs are enhanced and a sense of self-worth is developed. For example, Argyle (1987) suggested that Scottish country dancing epitomises the totality of an enhancing activity in which there is social contact, skill, exercise and involvement in culture. Gardening can be understood in the same light; although different in pace, it provides the participant with closeness to the seasons and the rhythm of life. It enhances the quality of life by the provision of colour, smell, experiences and the produce which results from careful tending.

Giving people opportunities to take part in demanding and challenging activities makes them less sensitive to risk and more able to cope with physical and emotional demands (Newman 2002). A person needs to experience demands that are within his capabilities, or that stretch him slightly, in order to develop a sense that he can manage. If the demands are too great, leading to repeated failure, or too light, so that skills are not developed, then the individual will not be able to trust in his ability to cope (Antonovsky 1993).

OCCUPATIONAL THERAPY AND WELL-BEING

The occupational therapy process, as outlined by Reed & Sanderson (1992), focuses on leisure, personal care and occupation in relation to the physical, psychological, social, economic and spiritual aspects of a person's life. External factors, both sociological and environmental, are taken into account and there is an emphasis on enhancing the competence of the individual rather than highlighting areas of disability or malfunction. The

philosophy underpinning this approach, which is essentially holistic and focused towards empowerment, is compatible with health promotion and the concepts of personal responsibility and control.

The wellness and holistic health movement in America, which emerged from the human potential and counter-culture movements in the 1960s and 1970s (Johnson 1986), fitted well with philosophies in occupational therapy that acknowledge the dynamic interaction of mind, body, spirit and social context. The focus on spiritual well-being encompasses the values of the individual and recognises the need for self-esteem and affirmation. Without some sense of spirituality, there is a lack of meaning in life, which can often be identified in loneliness, depression and feelings of powerlessness (Neuhaus 1997).

A client-centred focus will in itself help to combat problems. Many people lack experience of warm and supportive relationships and the therapist can facilitate the expansion of social networks to enhance feelings of well-being.

Some of the factors which promote a sense of well-being are reflected in the following six Cs.

- **Contribution.** An old Indian 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 lead 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 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 of direction in life.

THE CONTRIBUTION OF OCCUPATIONAL SCIENCE

The discipline of occupational science is concerned with the form, function and meaning of occupation. While its relationship with the practice of occupational therapy is a robust one, it draws its knowledge base from diverse interdisciplinary sources. This provides a rich contribution to our understanding of how occupation affects mental health and subsequent well-being. Yerxa (1993) was an early proponent of this new science, believing that it offered a new way to comprehend the occupational nature of human beings and how this could enhance human potential and personal growth.

A number of theorists (for example, Clark 1993, Townsend 1997, Watson & Swartz 2004) have extended these ideas and offered a type of qualitative research methodology in the form of narrative analysis which has revealed how engagement in meaningful activities can be a transformative experience. Further, occupational patterns and routines provide a sense of coherence and balance (Ekelman et al 2003). Mental well-being can be enhanced by the significant social, spiritual, psychological and biological features which a balanced occupational life offers (Wilcock 2006). Occupational balance is the result of healthy resolution of occupational deprivation, alienation and injustice, through the achievement of occupational justice (Townsend 2003, Whiteford 2000, Wilcock 1998).

SUMMARY

Prevention of ill health and the promotion of mental well-being are now regularly featured within the media. In one popular evening newspaper in the East of Scotland, on one night alone, there were features concerning volunteering to promote good mental health, an article advertising a module to assist police officers to recognise the signs of dementia in the course of their work and a feature on ways of combating depression in young men.

This chapter has explored some of the concepts and ideas that underpin the promotion of mental

health and well-being. It has identified the factors that have the potential to promote or inhibit positive mental health and looked at some of the strategies and interventions used in mental health promotion programmes. It finished by considering the role of occupational therapy in the promotion of health and well-being, and the contribution that occupational science is making to the field.

The early years of the new millennium have been exciting ones for the profession of occupational therapy in relation to ideas of health, wellness and well-being. Occupational perspectives of health

are now more confidently articulated, whether in relation to micro, meso or macro aspects of society. The underlying philosophy of occupational therapy is consistent with models of health which focus on the empowerment of individuals by acquiring life skills to achieve a greater sense of control. It is concerned with the constellation of activities which give meaning to life by determining roles, relationships and routines. These give shape and purpose to our lives and provide the vital ingredients that contribute to a sense of well-being.

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