PART 1

Health Promotion and Theory

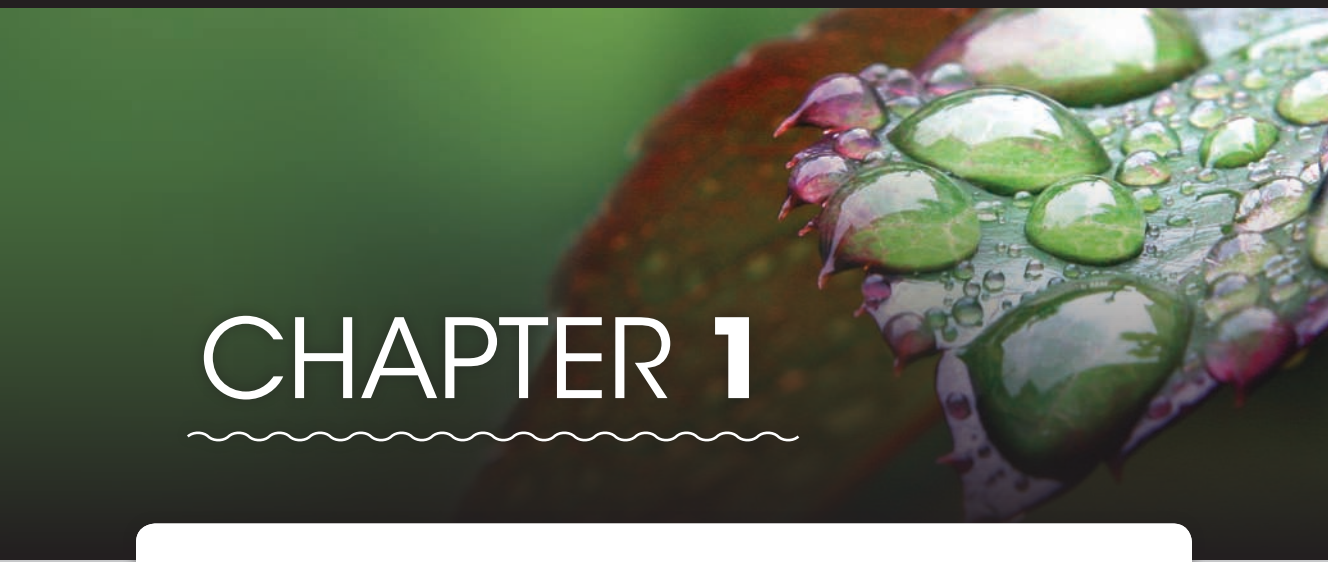
LEARNING OBJECTIVES

Upon completion of this chapter, you will be able to:

1. Discuss the concepts of patient versus client.
2. Analyze the historical evolution of the multidimensional aspects of health.
3. Contrast the concepts of health and wellness.
4. Compare the dimensions of health on the health–illness continuum.
5. Contrast the various definitions of health promotion.
6. Identify the six key aspects of health and analyze the factors that are determinants of health.
7. Define ethnomedical ethnic systems and explain how cultural factors may affect health promotion.
8. Differentiate the three levels of disease prevention: primary, secondary, and tertiary.
9. Discuss key aspects of Leavell and Clark's conceptual map of prevention.

KEY TERMS

Adaptive dimension
Client
Clinical dimension
Determinants of health
Dimensions of health
Disease prevention
Eudaimonistic dimension
Health
Health versus wellness
Health promotion
Healthy People 2020
High-level wellness
Primary prevention
Quality of life
Role-performance dimension
Secondary prevention
Tertiary prevention
Wellness



CHAPTER 1

Health and Health Promotion

- Introduction
- What Is Health Promotion?
- Disease Prevention
- Final Thoughts: Evidence-Based Practice and Dealing with Data Overload
- Summary

http://go.jblearning.com/healthpromotion

For a full suite of assignments and learning activities, use the access code located in the front of your book to visit the exclusive website: http://go.jblearning.com/healthpromotion If you do not have an access code, you can obtain one at the site.

Introduction

Despite being the central focus (and goal) of health promotion, health and its definitions are not simple matters. Health can mean different things to different people.

Health promotion often demands a significant, if not total, effort from each person in order to evolve. For that reason, throughout this book, we use the word **client** to indicate a more equal level of power in the relationship. As one client said,

> As a patient, I am clearly at the mercy of someone else who holds the cards. They decide things for me, not with me. They do things to me and I rarely have a real choice. It is often a subordinate relationship. The word "client" implies that I am a consumer with free will and the ability to make choices. (Baird, 2011, p. 1)

Given this power, a client's definition of what's healthy may conflict with the nurse's ideas about how to promote health. So, it is important to start with a few basic points about our central concept.

An Evolving Definition of Health

Florence Nightingale (FIGURE 1-1) described modern concepts of health and health promotion in her publication, *Notes on Nursing*. She published her book in 1860, but the interventions she described were decades ahead of their time.

FIGURE 1-1 Florence Nightingale
Source: National Library of Medicine

Nightingale developed her definitions of health during the Crimean War while working in unsanitary conditions. From these experiences, she developed a novel concept. She recognized that disease stemmed from factors that could be addressed *before illness developed* by paying attention to physiologic or environmental processes that laid the groundwork for the disease. She described how factors such as hunger, basic sanitation, overcrowding, poor nutrition, and lack of clean drinking water affect health. She argued that nurses must be concerned with each of these if we wish to support the reparative process that the body undertakes naturally (Nightingale, 1860).

In Nightingale's time, and up until World War II, infectious diseases caused most deaths worldwide. They defined **health** as the absence of infection in an individual. Prior to the war, international consensus defined health simply as the absence of disease or illness World Health Organization [WHO] (1958, p. 1).

As knowledge grew, the term, *health*, became multidimensional. In recognition of this reality, in 1946, the World Health Organization (WHO) began its constitution by emphasizing the concept of wholeness and positive qualities of health with the following definition: "Health is a state of complete physical, mental, and social well-being and not merely the absence of disease and infirmity" (WHO, 1948, p. 1). This definition implies that there is an intrinsic relationship between the body and the welfare of the self.

In the more than 60 years since WHO's constitution was written, definitions of health have broadened to include spiritual and emotional aspects. In 1986, WHO (p. 1) expanded upon its original definition (see BOX 1-1) to note that "[h]ealth is a positive concept emphasizing social and personal resources, as well as physical capacities." In 2006, WHO added two new concepts to its health lexicon: that of wellness, which was defined in terms of optimal physical, psychological, spiritual, and economic health as well as the ability to fulfill social roles, and global health, which acknowledged for the first time the global impacts of certain health issues (Smith, Tang, & Nutbeam, 2006).

BOX 1-1 The World Health Organization's Evolving Definitions of Health and Wellness

- WHO, 1946: "*Health* is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity."
- WHO, 1986: "*Health* is . . . 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."
- SMITH, TANG, & NUTBEAM, 2006: "*Wellness* is the optimal state of health of individuals and groups . . . [including] the realization of the fullest potential of an individual physically, psychologically, socially, spiritually and economically, and the fulfillment of one's role expectations in the family, community, place of worship, workplace and other settings."
- SMITH, TANG, & NUTBEAM, 2006: "*Global health* refers to the transnational impacts of globalization upon health determinants and health problems which are the beyond the control of individual nations."

REFERENCES

Smith, B. J., Tang, K. C., & Nutbeam, D. (2006). "WHO health promotion glossary: New terms." *Health Promotion International, 21*(4), 340–345.

World Health Organization. (1946). *Preamble to the Constitution of the World Health Organization*. Signed at the International Health Conference, New York, July 22, 1946.

World Health Organization. (1986). *Ottawa Charter for Health Promotion*. First International Conference on Health Promotion, Ottawa, Canada, November 21, 1986—WHO/HPR/HEP/95.1.

For our purposes, we will use Murray and colleagues' (2009) definition of health:

> Health is a state of well-being in which the person uses adaptive responses physically, mentally, emotionally, spiritually, and socially in response to external and internal stimuli or stressors. The purpose of health is to maintain relative stability and comfort and to achieve personal objectives that emphasize characteristics of strength, resilience, resources, and capabilities rather than on pathology. (p. 2)

Health is a state of well-being. Health is the place we are at at any given moment in relation to our physical, emotional, social, spiritual, and intellectual self. Health is believed to exist throughout life, interspersed with periods of injury, illness, or disease. Optimal health is a dynamic balance of physical, emotional, social, spiritual, and intellectual health. Health can be measured with thermometers, blood pressure machines, and blood tests, but **wellness** is the client's assessment of his or her physical, emotional, social, spiritual, environmental, and intellectual status. It is possible to be dying and still feel well if death is accepted and peace is prevalent.

Dunn (1961) coined the term **high-level wellness**. Key concepts include maximizing one's potential, having direction and purpose in life, meeting the challenges of the environment, looking beyond the needs of self to the needs of society, and doing it all with joy or a zest for life. In this framework, the nurse is a facilitator who teaches clients how to self-assess, decide on wellness goals, plan on actions to meet those goals, and self-evaluate success.

The evolution of the definitions of health and wellness reflects a growing understanding that while being healthy is primarily associated with the absence of disease, health and wellness are not absolute conditions, nor are they usually perceived that way.

Here is an example: According to results from the Canadian Community Health Survey–Healthy Aging, 76% of Canadians in mid-life (45 to 64 years old) and 56% of seniors reported that they experienced "good health" in 2009 (Ramage-Morin, Shields, & Martel, 2010). This is based on a definition of health composed of positive self-perceived general and mental health and wellness, functional ability, and independence in activities of daily living. Good health, according to this definition, was reported even by persons who had chronic conditions such as high blood pressure, arthritis, and back problems, all of which were common among people aged 45 or older.

Most individuals want to be healthy, however they define that state. Even when optimal health is not a reasonable possibility (in persons with chronic diseases or disabling conditions, for example), a wish to be healthier is common. At its foundation, **health promotion** is a method that seeks to help individuals, families, and communities reach this goal. We will further define health promotion later in this chapter.

Multiple Dimensions of Health

As noted earlier, health is multidimensional—so health can be promoted along a number of different routes. Before delving into a more complex definition of health promotion, it is worth discussing what these dimensions might be.

Smith (1983) provided a description of health that may be useful. This description involves underlying concepts of actualization and stability. In this description of health, each dimension is defined by extremes on the health–illness continuum.

1. *Clinical dimension:* In this dimension, the absence of disease signs and symptoms indicate health. Illness would be at the extreme opposite with obvious identifiable evidence of disease through specific signs and symptoms. Health extreme: absence of signs or symptoms of disease. Illness extreme: presence of signs or symptoms of disease.
2. *Role-performance dimension:* This dimension defines health as the ability of a person to perform social roles, including those involving work and family, based on societal expectations. Illness is when the person is unable to perform his or her role at this level of expectation. Health extreme: performance of social roles with maximum output. Illness extreme: failure to perform one's social roles.
3. *Adaptive dimension:* This is defined by the ability to adapt positively to social, mental, and physiological change for health, while illness means failure to adapt. Health extreme: flexible adaptation to the environment. Illness extreme: alienation and maladaptation to the environment.
4. *Eudaimonistic dimension:* This dimension is derived from a Greek term that means exuberant well-being. One end of the dimension includes positive interaction among the physical, social, psychological, and spiritual aspects of the environment, while the other includes a lack of involvement or apathy/wasting away due to illness. Health extreme: exuberant well-being. Illness extreme: devitalized with increasing debility.

When you seek to promote health in an individual, a family, or a community, any (or all) of these ***dimensions of health*** can become a focal point for health promotion efforts. Your role is to identify where, in each of these dimensions, the client can move toward wellness and to actively work to promote improvement along each axis (FIGURE 1-2). It is not enough to simply address the clinical dimension in a client who has a disease, given that many factors contributing to the disease occur along other dimensions.

Consider the following hypothetical example: Suppose you are asked to work with a 40-year-old man, married 15 years with two young children, who is suffering from chronic lower back pain related to a car accident that took place 18 months prior. He has been using opiate pain medications since the accident, but he complains that they are not always effective anymore. He has been offered higher doses by his doctor, but he worries about becoming

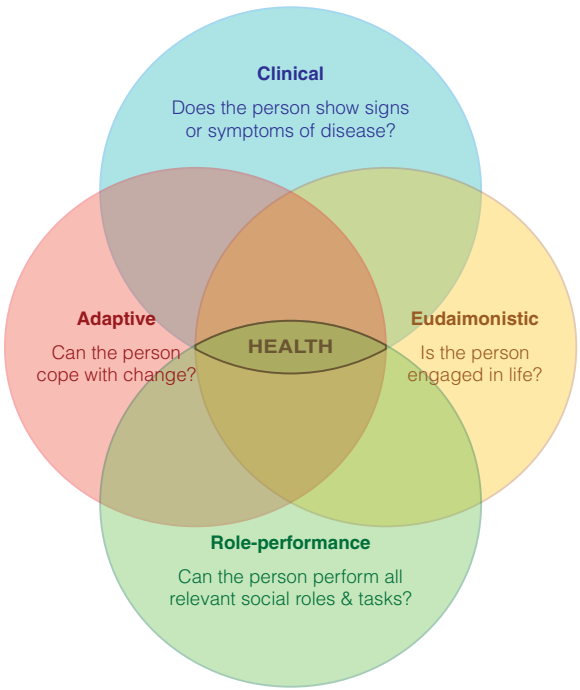


FIGURE 1-2 Multiple Dimensions of Health

addicted to opioids and fears that keeping such drugs in the house will make him vulnerable to thieves if anyone should find out he has them. As a result, he is often in significant pain. The pain affects the man's ability to work, play with and care for his children, and participate in sports and many other activities he used to enjoy. He tries to work through the pain but often is not successful, and his mood varies in accordance with his success. At times, he is irritable, depressed, and prone to lashing out at his wife and kids, and his relationship with his family has been adversely affected as a result. He comments that at 40, he did not expect to be a decrepit old man already.

This hypothetical client offers a number of opportunities for successful interventions. First, let us look at the clinical dimension. Pain management through opioid medications (e.g., oxycodone) is attractive because pain relief is thorough and, for short, acute bouts of pain, the likelihood of drug tolerance or dependence is limited. While they are an option for acute episodes of severe pain, opioids do not work better than NSAIDs for long-term, chronic pain conditions, yet they have a stronger likelihood of addiction and misuse when used for more than a few months (Jamison, Serraillier, & Michna, 2011; White, Arnold, Norvell, Ecker, & Fehlings, 2011). While concerns about addiction, the development of drug tolerance, and withdrawal symptoms upon discontinuation are probably the most significant drawbacks, of opioid use there are other clear-cut physiologic side effects, apart from addiction, that make opioids less attractive for treating chronic pain long-term (Furlan, Sandoval, Mailis-Gagnon, & Tunks, 2006; Gore, Sadosky, Leslie, Tai, & Emery, 2012; Von Korff, Kolodny, Deyo, & Chou, 2011). Constipation, dizziness, drowsiness, and nausea are among the most common side effects, and delayed gastric emptying, immune suppression, and muscle rigidity are known to occur in long-term opioid treatment. Opioids also tend to work less effectively on pain related to the central nervous system (brain and spinal cord) (Benyamin et al., 2008).

These clinical facts, taken together, support the client's wish to find an alternative to opioid pain medications. But even more important are the factors related to other dimensions of health. The client's physical condition impairs

his ability to function in his roles as an employee, a husband, and a father—and, as revealed by his concern about theft, as a family protector. While pain may be causing some of his mood swings, it is likely that his poor health in the role-performance dimension is also affecting his mood. The stress he experiences as a result of his inability to meet the expectations of his roles may in turn be adding to his physical pain.

He is also doing poorly in terms of his adaptive and eudaimonistic dimensions. His sole strategy for coping is to work through the pain by ignoring his body's signals regarding its needs in order to meet the need to fulfill his roles. This decision puts his personal well-being in direct conflict with his role-performance needs and results in poor outcomes on *both* fronts. The outbursts of anger are a clear indication that he is unable to manage the stress of juggling these conflicts, and he is also is unable to find alternative solutions.

This is where a nurse trained in health promotion can offer some assistance. The nurse can address the clinical issue—back pain—by providing information about safe and effective nonmedical approaches and allowing the client to choose which method of safe pain relief might be best for him. You can ask the client if he would like to learn progressive relaxation or listen to a relaxation tape that can help relax his muscles and reduce pain. The nurse can also refer the client to a massage therapist or to physical or occupational therapy that will retrain him to use his body in ways that support his back's normal functioning. Other options include offering alternate forms of pain relief, such as acupuncture, which has been shown to be effective in pain relief (Manheimer, White, Berman, Forys, & Ernst, 2005; Moritz et al., 2011; Trigkilidas, 2010). These actions will not only address the clinical issue, but also will address one of the client's emotional concerns by supporting his desire to keep opioid drugs out of his home. Unless the other three dimensions on the health–illness continuum are addressed, his *total* health may not improve. This client needs to learn adaptive strategies for managing his pain, rather than ignore it. The nurse can offer the client cognitive behavioral therapy, meditation, and other methods of mind–body management as appropriate measures to help the client learn better coping skills and explore new ways of fulfilling his roles (Thorn et al., 2011). (These measures are discussed elsewhere in this text.) In such cases, the nurse's role is to look beyond the simple clinical manifestations of physical illness and address the factors that are causing the client distress on all levels.

To obtain more information about personal and global well-being, explore the website at http://www.nationalaccountsofwellbeing.org/explore/indicators/zsocial

Mental Health

Throughout much of history, concepts of health focused primarily on the health of the body. It has not been until fairly recently that mental health has

been recognized as a key factor in the health of a person in terms of the connections between body, mind, and spirit. The Surgeon General's 1999 report on mental health explained these connections succinctly:

> Considering health and illness as points along a continuum helps one appreciate that neither state exists in pure isolation from the other. In another but related context, everyday language tends to encourage a misperception that "mental health" or "mental illness" is unrelated to "physical health" or "physical illness." In fact, the two are inseparable. (Office of the Surgeon General, 1999, p.1)

Mental health overlaps physical health in that many psychiatric and developmental disabilities are founded in physiologic issues, which can include genetic disorders, injuries to the brain and nervous system, neurochemical imbalances, early learned behaviors, and even nutritional deficits. The manifestations of mental health disturbances often affect the emotional and social realms and vice versa. For this reason, mental health issues have often been met with fear, misunderstanding, and contempt by society at large and even some healthcare professionals. While great strides have been made in understanding the origins of psychiatric and psychological disorders, mental health issues still carry significant stigma (Parton, 2011). This stigma, as well as the disorder itself, can represent both a significant burden to physical health and a barrier to health promotion.

While this stigma continues, hope is born in a study that looks at primary prevention of mental health problems in Australia. The researchers investigated changes in standardized academic performance across the 2-year implementation of a mental health initiative in 96 Australian elementary schools that focused on improving student social–emotional competencies. They used the KidsMatter program, and after controlling for socioeconomic differences, they found a significant positive relationship existed between quality of implementation and academic performance. The difference between students in high- and low-implementing schools was equivalent to a difference in academic performance of up to 6 months of schooling. The key practitioner message is that, given the known relationship between student academic achievement and mental health, many nations are mounting school-based mental health interventions (Dix, Slee, Lawson, & Keeves, 2012).

Quality of Life

Another consideration that has developed in recent decades is concern for an individual's **quality of life**. Quality of life is almost wholly subjective, because it centers around the individual's own sense of well-being, which is itself hard to define (Andrews & Withey, 1976; Diener, 2000; Ryff & Keyes 1995; Wiseman, McLeod, & Zubrick, 2007):

> There is no consensus around a single definition of well-being, but there is general agreement that at minimum, well-being includes the presence of positive emotions and moods (e.g., contentment, happiness), the absence of negative emotions (e.g., depression, anxiety), satisfaction with life, fulfillment and positive functioning. (Centers for Disease Control and Prevention [CDC], 2011)

Individuals with significant physical disabilities can, and often do, have high quality of life. In the presence of significant physical illness, maximizing quality of life is often part of the health goal, particularly if there is no method of reducing or alleviating physical symptoms. In contrast, some mental health issues can markedly reduce the quality of life in even a person with good physical health—and in extreme cases, mental health issues affect physical health negatively, which further reduces quality of life. Quality of life is therefore a central concern for people suffering from both mental and physical illness. Taking a wellness approach and asking clients to define what they mean by quality of life could be a first step in clarifying the confusion.

HEALTH PROMOTION CHALLENGE

If you were to develop a tool to help clients define their quality of life, what would you include and how would you test it out?

What Is Health Promotion?

Health promotion has evolved over the past 30 years; as a result, it has as many definitions as the concept of health itself does. Each one generally entails the concept of improving the health of individuals, families, and communities.

In its 1986 *Ottawa Charter for Health Promotion* (p. 425), WHO defined health promotion as "the process of enabling people to increase control over, and to improve, their health." This definition was groundbreaking in that it directly states that individuals should be actively engaged in supporting their own health. However, the charter offers no suggestions as to how the health promotion process works. A more detailed definition of health promotion proposed by Maville and Huerta (2002) reflects the multiple themes and issues found in the literature:

> Health promotion is any endeavor directed at enhancing the quality of health and well-being of individuals, families, groups, communities, and/or nations through strategies involving supportive environments, coordination of resources, and respect for personal choice and values. Related concepts, including health

> education, health protection, and disease prevention are part of the broader concept of health promotion. The definition that an individual or organization adopts depends upon political, societal, and philosophical viewpoints (p. 3).

These points are consistent with what the World Health Organization incorporates into its definition of health, including positive attributes that consider not only the person's physical aspects, but also their social and personal resources (WHO, 1986).

Still other definitions exist, and some have nuances that merit attention. For example, consider each of the following alternate definitions of health promotion:

1. Health promotion is behavior motivated by the desire to increase well-being and actualize human health potential, whereby disease prevention or health protection is behavior motivated by a desire to actively avoid illness (primary prevention), detect it early (secondary prevention), or maintain functioning within constraints of an illness (tertiary prevention) (Pender, Murdaugh, & Parsons, 2006).
2. Health promotion is the art and science of helping people discover the synergies between their core passions and optimal health, enhancing their motivation to strive for optimal health, and supporting them in changing their lifestyle to move toward a state of optimal health. Optimal health is a dynamic balance of physical, emotional, social, spiritual, and intellectual health. Lifestyle change can be facilitated through a combination of learning experiences that enhance awareness, increase motivation, and build skills and, most important, through the creation of opportunities that open access to environments that make positive health practices the easiest choice (O'Donnell, 2009, p. iv).
3. Health promotion is the process of advocating health in order to enhance the probability of personal (individual, family, and communities), private (professional and business), and public (federal, state, and local government) support of positive health (Dwore & Kreuter, 1980, p. 103).

In the first alternate definition, health promotion focuses on disease prevention and improving well-being in an individual client, with the emphasis on the client's own behavior. In the second, the focus is on lifestyle and optimal health, again for individuals, but with an emphasis on the provider's role in the process. The third expands its focus beyond the individual and defines health promotion from the point of view of advocacy.

What is interesting about all of the definitions discussed here is that they each have different ideas about where health promotion takes place and who is responsible for promoting health. We see definitions that focus on the individual and on society at large, and we also see a perspective that emphasizes personal initiative on the part of a client set in contrast to the role of the nurse or healthcare provider. Are any of these perspectives correct? Or are they all

aspects of health promotion? We would argue that health promotion as a discipline encompasses them all.

In practice, health promotion includes any or all of the following:

- Providing a combination of educational and environmental supports for actions and conditions of living conducive to health
- Using various methods to induce lifestyle change through a combination of efforts to enhance awareness, change behavior, and create environments that support good health and have the greatest impact in producing lasting changes
- Helping people discover the synergies between their core passions and optimal health by facilitating lifestyle change through a combination of experiences that enhance awareness, increase motivation, and build skills by creating open access to environments that make positive health practices the easiest choice

Health Promotion: Perspectives and Concepts

The main concepts that separate health promotion from most other types of healthcare philosophy include:

1. A holistic view of health
2. A focus on participatory approaches
3. A focus on the determinants of health—the social, behavioral, economic, and environmental conditions that are the root causes of health and illness
4. Building on existing strengths and assets, not just addressing health problems and deficits
5. Using multiple, complementary strategies to promote health at the individual, family, and community levels

The previous list includes the term **determinants of health**. This term is important to comprehend not only to aid in understanding the definition of health promotion, but also when reviewing ***Healthy People 2020*** documents, which will be outlined in another chapter. Determinants of health is a very broad term that refers to a range of factors, including social, economic, and environmental factors that contribute to determining the health status of an individual, a family, or communities. These factors, outlined by Nutbeam (1998), include the following:

1. Income and social status
2. Social support networks
3. Education (including both literacy and health literacy)
4. Employment and working conditions
5. Physical environments
6. Social environments

7. Biology and genetic endowment
8. Health service
9. Cultural concepts of health

Other determinants of health may be identified as well; this list is not intended to be all-encompassing, but represents most of the basic factors that determine health.

HOT TOPICS

Here are some topics to explore:

- Quality of life research
- Holistic health
- Healthy People 2020
- Health insurance
- Health disparities

From the practical point of view, health promotion can be defined as any activity undertaken for the purpose of achieving a higher level of health and well-being. Health promotion activities are directed toward developing client resources that maintain or enhance well-being, not just avoiding or preventing disease. Health promotion includes both prevention and wellness activities and may be focused on physical, emotional, social, intellectual, spiritual, or environmental aspects of health.

Physical aspects of health include:

- Fitness
- Nutrition
- Self-care
- Substance abuse (note that substance abuse may also have emotional, social, and spiritual ramifications as well)

Emotional aspects of health include:

- Coping skills during an emotional crisis
- Stress management
- Quality of life
- Self-esteem and self-efficacy

Social aspects of health include:

- Community involvement
- Family relationships
- Friendships
- Geographical factors (rural vs. urban)
- Socioeconomic status and income

Intellectual aspects of health promotion include:

- Education
- Health literacy (note that well-educated people may still know little about health)
- Achievement
- Career development
- Access to technology

Spiritual aspects of health promotion include:

- Love
- Hope
- Charity
- Life purpose

Environmental aspects of health promotion include:

- Living in a nontoxic environment
- Working in a nontoxic environment
- Attending school in a nontoxic environment
- Availability of local resources to promote health (e.g., healthcare providers, pharmacies, facilities for exercise, wellness programs)

Cultural Ideas about Health

There is another determinant of health that bears discussion: the cultural dimension of how health is defined. Individuals may have different perspectives on what health means within a culture, but, social groups that derive from different cultures of origin also sometimes have widely differing ideas of what constitutes health, both for the individual and for the society. When working with a client from a particular ethnic or cultural group, it is important that the nurse gain some understanding of the client's ethnomedical system (this is the client's cultural perspective on health)—both with respect to what constitutes health and how health is maintained. Medical anthropologist Mark Edburg explains why this matters:

> [We] can define an ethnomedical system as an applied cultural knowledge system related to health that sets out the kinds of health problems that can exist, their cause, and . . . appropriate treatments. . . . Of key importance when thinking about the cultural aspect of ethnomedical systems is that, across cultures, there are different answers to [medical] questions, from the range of potential health problems, to causes, to treatments, as well as the closely related question of what kinds of individuals are qualified to provide treatment. This means that if you are working in health promotion, prevention, or intervention efforts across cultures, you may define a health problem as, say, the flu, and understand it to be caused by a particular virus; while the people with whom you are working may define it differently—as, for example, a set of symptoms that are the result of improper social relations (e.g., behavior motivated by jealousy). Remember, human beings are biocultural. For this reason, in talking about

> ethnomedical systems, some theorists have found it useful to make a distinction between a disease (an abnormal biomedical state caused by pathogens or physical anomalies) and an illness (a culturally defined state of not being well, with many culturally defined causes, including biomedical) . . . Diseases and illnesses may or may not refer to the same phenomenon. (Edburg, 2012, p. 39)

The impact of differences in ethnomedical concepts upon health promotion is illustrated by a study (Holdsworth, Gartner, Landais, Maire, & Delpeuch, 2004) in which women from Senegal—where having a large body is regarded as a sign of prosperity and fertility—were shown body silhouettes of various body types and asked to ascribe personality traits to those bodies. The outcomes of the study showed that the women considered the silhouettes showing an obese body type as having

> a range of positive personal attributes—warm, happy, popular, friendly, proud, sociable, easy going, and having a strong personality. Body size profiles leaning towards the overweight were also seen as having the highest social status, a good job, enough money, a contented husband, children, proud family in-laws, and a higher likelihood of getting married. (Edburg, 2012, p. 18)

Knowing this, you can imagine that a nurse working with a female client from this cultural background might have difficulty convincing that client to undertake a weight management program—even if the client had developed weight-related physical diseases or conditions such as diabetes, hypertension, joint pain, breathing difficulties, and so forth. Regardless of what the client's biomedical circumstances might be, the cultural support for maintaining high body mass outweighs the incentive to lose weight.

Health promotion efforts in this case may involve raising the client's awareness of how her own cultural assumptions may impede her physical health, but understand that challenging deeply held cultural norms may not be a beneficial strategy unless the client appears open to it—for instance, a recent immigrant from Senegal may hold onto such norms as a way of maintaining contact with the familiar ideas of home, but a second-generation immigrant or younger woman might be more receptive to the idea that weight reduction would benefit her.

Another strategy may involve shifting emphasis from weight loss to improving physical fitness. That is, the nurse may have better results if instead of putting her Senegalese client on a weight loss program, she instead presents the client with an expectation of improved physiologic condition leading to relief of unpleasant symptoms related to poor fitness (e.g., joint pain, breathing issues). Make it clear to the client that part of the trade-off would be loss of some of the weight that the client prizes. Highlighting the benefits of this trade-off and keeping the client focused on the positive results ("Are you feeling less pain now in your joints?" "How has your blood pressure been lately?") can help alleviate some of the emotional distress the client may feel at undertaking a program that contradicts cultural imperatives.

Learn enough about the client's cultural perspectives to make effective suggestions without resorting to stereotyping. There are several ways to do this:

- Reading anthropological literature on the cultural history of the ethnic group in question (useful if you regularly serve individuals from this community, but not likely a good use of time if this ethnic group represents a small subset of clients)
- Reviewing the health literature for studies relating to interventions in the ethnic group of interest
- Interviewing the client and family members about cultural beliefs and expectations regarding health. (This might be your best bet because not all members of a cultural group adhere to all beliefs or expectations. Such action would also help build rapport with the client.)
- Developing a community-based research study to identify cultural beliefs about health (again, useful if the ethnic group of interest is widely represented among clients).

Keep in mind, though, that however well versed you might become in traditions and ethnomedical perspectives of a particular ethnic group, clients need to be regarded as individuals first, and representatives of their cultural tradition second. Individuals can and often do have ideas that conflict with their own cultural norms, and these should be respected and honored.

It is also important to recognize that ethnic origin and cultural background are not necessarily the same thing. International adoptions are very common,

CULTURAL RESEARCH STUDY

A review of: Health Disparities in Lifestyle Choices Among Hypertensive Korean Americans, Non-Hispanic Whites, and Blacks

This study gathered data from 100 hypertensive Korean Americans (KAs) about medications, diet, and exercise/physical activity and compared this data to matched individuals from the National Health and Nutrition Examination Survey (NHANES III) who were non-Hispanic Whites and Blacks. The results of the study indicated that the KAs were significantly less likely to reduce salt in their diets and follow advice for weight loss to reduce cholesterol levels. The KAs had lower body mass index, were older, and were more educated than the other two groups. They attended a KA clinic because of the respect they received and the use of the Korean language. The implications of this study included a suggestion of the need for KA healthcare providers to place more emphasis on health-promoting lifestyles with their patients. In addition, it was suggested that healthcare providers needed to treat all patients with respect and be sensitive to language needs.

Source: Kim, M. J., Ahn, Y. H., Chon, C., Bowen, P. & Khan, S. (2005). Health Disparities in Lifestyle Choices among Hypertensive Korean Americans, Non-Hispanic Whites, and Blacks. *Biological Research for Nursing, 7*(1), 67–74.

and you may encounter individuals who are ethnically from one population but who have grown up in a household with significantly different cultural norms from those of the ethnic group of origin. Make no assumptions about ethnomedical systems based on a client's ethnicity. Instead, ask what health and health care mean so that an intervention is tailored to the client's perspective, rather than a stereotype.

Disease Prevention

It is virtually impossible to discuss health promotion without taking into account one key component: disease prevention. **Disease prevention** is defined as taking steps to avoid illness and the agents of illness. These steps include measures to identify risk factors for illness, since avoiding illness is difficult when the factors that contribute to illness are not known. Risk assessment is particularly important for preventing noninfectious diseases like diabetes or cancer, but it is also key to preventing infections that have specific, controllable transmission vectors, such as sexually transmitted diseases, where risk rises in direct relation to an individual's use of safe sex practices and number of sexual partners. Much of the research around risk assessment for disease prevention has been done by the United States Preventive Services Task Force.

In 1965, Leavell and Clark outlined three different forms of prevention: primary, secondary, and tertiary (FIGURE 1-3). We will discuss each in turn.

Primary Prevention

Primary prevention can only occur before someone contracts a disease or condition. Primary prevention aims to prevent the disease from occurring, thereby reducing both the incidence and prevalence of a disease. Prevalence (the proportion of a population that has the condition at a given time) depends on both the incidence (the rate of a new problem arising during a period of time) and the duration of the condition.

Primary prevention activities aimed at an individual's health are a set of actions that prevent a specific targeted condition. Prevention precedes the disease or condition. The activities decrease or even prevent the probability of occurrence of an injury, physical or mental illness, or a health-threatening situation in an individual or family, or an event or illness in a population. Some examples of primary prevention would include teaching new parents

Primary prevention:
avoiding exposure to a disease-causing agent.

Example: primary prevention of skin cancer includes:
- wearing sunblock
- seeking shade
- limiting sun exposure during peak hours

Secondary prevention:
taking steps to limit risk and detect disease after exposure occurs.

Example: secondary prevention of skin cancer includes:
- routinely checking skin for suspicious changes
- avoiding further sun exposure and sunburn

Tertiary prevention:
reducing effects of disease once symptoms are apparent.

Example: tertiary prevention of skin cancer includes:
- removing any suspect moles or lesions
- obtaining a biopsy specimen for analysis
- seeking immediate treatment if cancerous cells are detected

FIGURE 1-3 Three Types of Prevention

how to care for a newborn infant; the health problems being prevented are both health issues in the newborn from improper care as well as stress-related mental health problems in the parents. Another example would be working with a client concerned about weight gain to develop better diet and exercise habits (to prevent a variety of weight-related illnesses). Primary prevention is not undertaken only by people with no health issues—very few people would qualify! Primary prevention also includes encouraging a client with osteoporosis to use adequate daytime lighting, wear nonslip footwear, and have available a bedside bell, flashlight, walker, cane, and/or assistance when necessary. Such actions are known to prevent falls, which are the leading cause of debilitating

RESEARCH BOX: Sedatives, Mood-Altering Drugs Related to Falls Among Elderly

» BACKGROUND: There is increasing recognition that the use of certain medications contributes to falls in seniors. Our objective was to update a previously completed meta-analysis looking at the association of medication use and falling to include relevant drug classes and new studies that have been completed since a previous meta-analysis.

» METHODS: Studies were identified through a systematic search of English-language articles published from 1996 to 2007. We identified studies that were completed on patients older than 60 years, looking at the association between medication use and falling. Bayesian methods allowed us to combine the results of a previous meta-analysis with new information to estimate updated Bayesian odds ratios (ORs) and 95% credible intervals (95% CrIs)

» RESULTS: Of 11,118 identified articles, 22 met the inclusion criteria. Meta-analyses were completed on 9 unique drug classes, including 79 081 participants, with the following Bayesian unadjusted OR estimates: antihypertensive agents, OR, 1.24 (95% CrI, 1.01-1.50); diuretics, OR, 1.07 (95% CrI, 1.01-1.14); β-blockers, OR, 1.01 (95% CrI, 0.86-1.17); sedatives and hypnotics, OR, 1.47 (95% CrI, 1.35-1.62); neuroleptics and antipsychotics, OR, 1.59 (95% CrI, 1.37-1.83); antidepressants, OR, 1.68 (95% CrI, 1.47-1.91); benzodiazepines, OR, 1.57 (95% CrI, 1.43-1.72); narcotics, OR, 0.96 (95% CrI, 0.78-1.18); and nonsteroidal anti-inflammatory drugs, OR, 1.21 (95% CrI, 1.01-1.44). The updated Bayesian adjusted OR estimates for diuretics, neuroleptics and antipsychotics, antidepressants, and benzodiazepines were 0.99 (95% CrI, 0.78-1.25), 1.39 (95% CrI, 0.94-2.00), 1.36 (95% CrI, 1.13-1.76), and 1.41 (95% CrI, 1.20-1.71), respectively. Stratification of studies had little effect on Bayesian OR estimates, with only small differences in the stratified ORs observed across population (for β-blockers and neuroleptics and antipsychotics) and study type (for sedatives and hypnotics, benzodiazepines, and narcotics). An increased likelihood of falling was estimated for the use of sedatives and hypnotics, neuroleptics and antipsychotics, antidepressants, benzodiazepines, and nonsteroidal anti-inflammatory drugs in studies considered to have "good" medication and falls ascertainment.

» CONCLUSION: The use of sedatives and hypnotics, antidepressants, and benzodiazepines demonstrated a significant association with falls in elderly individuals. Falls among elderly people are significantly associated with several classes of drugs, including sedatives often prescribed as sleep aids and medications used to treat mood disorders, according to a study led by a University of British Columbia expert in pharmaceutical outcomes research.

The study, published Nov. 23, 2009, in the *Archives of Internal Medicine*, provides the latest quantitative evidence of the impact of certain classes of medication on falling among seniors. Falling and fall-related complications such as hip fractures are the fifth leading cause of death in the developed world, the study noted.

Source: Woolcott, J. C., Richardson, K. J., Wiens, M. O., Patel, B., Marin, J., Khan, M. K., & Marra, C. A. Meta-analysis of the Impact of 9 Medication Classes on Falls in Elderly Persons. *Archives of Internal Medicine*, *169*(21), 1952–1960.

hip fractures in individuals with osteoporosis (Donat & Ozcan, 2007; Rubenstein, 2006; Stevens & Olson, 2000).

Primary prevention on a broader scale works toward combating harmful forces that operate on the individuals of the community by strengthening the capacity of people to withstand these forces (Murray et al., 2009). The purpose of community-level primary prevention programs is to decrease the vulnerability of the individual or population to disease or dysfunction. This can include health education about specific risk factors for a disease, promoting practices such as the use of helmets or other safety equipment, or providing protection from infection through dissemination of vaccines.

ASK YOURSELF

Community health is a topic that is important to all of us. Imagine you have decided to become more active in your community and would like to channel your energies in the direction where you can have some major impact. How would you determine what direction you should take? Who might you talk to? What organizations might you contact?

Leavell and Clark (1965) developed a conceptual map for community-based primary prevention. It included:

Health Promotion

1. Health education
2. Good standard of nutrition adjusted to developmental phases of life
3. Attention to personality development
4. Provision of adequate housing, recreation, and agreeable working conditions
5. Marriage counseling and sex education
6. Genetic counseling
7. Periodic selective examination

Specific Protections

1. Use of specific immunizations
2. Attention to personal hygiene
3. Use of environmental sanitation
4. Protection against occupational hazards
5. Protection from accidents
6. Use of specific nutrients
7. Protection from carcinogens

HEALTH PROMOTION CHALLENGE

Read the information in the RESEARCH BOX and develop a primary prevention nursing intervention for falls based on the study findings.

Secondary Prevention

Secondary prevention is the identification and treatment of asymptomatic persons who have developed risk factors or who have a disease that is in a preclinical state (that is, not yet clinically apparent). The goal of secondary prevention is to find and treat disease early, because many diseases can be cured more easily with early diagnosis. Secondary prevention consists of measures taken after exposure to the disease-causing factor has occurred, but before the person notices that anything is wrong. For example, secondary prevention of colon cancer would involve getting a colonoscopy to look for precancerous polyps. In contrast, primary prevention for colon cancer would involve eating a high-fiber diet that limits red meat and alcohol (that is, taking steps to lower risk of developing polyps and neoplastic changes in the first place).

Secondary prevention activities include screening techniques (e.g., mammograms, blood glucose testing, and similar routine tests) intended to offer an early diagnosis and prompt treatment of the existing health problem, disease, or harmful situation. Such measures are undertaken with the goal of shortening the disease's duration and severity of consequences so that the individual can return to his or her maximum potential health or normal functioning as quickly as possible.

Secondary prevention can also include actions taken to resolve a known factor in the home or the environment that contributes to increased risk of disease for a community. For example, efforts to reduce air pollution in urban areas may be considered secondary prevention for diseases such as asthma and chronic obstructive pulmonary disease (COPD), both of which are related to the overall levels of air pollution in urban environments (Kelly & Fussell, 2011).

Tertiary Prevention

Tertiary prevention targets the person who already has symptoms of the disease. Since it is no longer possible to prevent the disease itself from developing, the goals of tertiary prevention are:

- Prevent or limit damage and pain from the disease
- Slow down progression of the disease
- Prevent the disease from causing complications
- Give better care to people with the disease
- Assist people with the disease to be able to do what they used to do

An example of tertiary prevention includes teaching people with COPD to gain control over their breathing and breathe more efficiently; this can be achieved by using their breath to play a computer game that teaches them to inhale more slowly and exhale more completely (Collins, Langbein, & Fehr, 2008).

It is important to recognize that tertiary prevention is not curing a disease or restoring a person to perfect health—it is undertaken, mostly, in the setting of an irreversible health problem. The goal of tertiary prevention is to prevent progression of a disease or any of its complications, therefore minimizing the disease effects and disability. Tertiary prevention activities may also involve maintenance activities or assessment for preventing complications. For example, physical therapy and occupational therapy for a patient who has experienced a cerebrovascular accident would be considered a tertiary prevention intervention. The therapy will prevent contractures on the patient's affected side and assist the patient in relearning some activities that are key to independent daily living, such as eating, dressing, or writing without assistance. In addition, the patient would be taught ways to maintain an appropriate blood pressure to limit the risk of another incident.

Final Thoughts: Evidence-Based Practice and Dealing with Data Overload

Health promotion does not consist of any one set of activities, techniques, or methods. As nursing practice is continually changing, with new therapies and tools being developed daily, so also are health promotion techniques. Nursing professionals advocate for evidence-based practice, but to create a health-promotion program supported by evidence, it is important to keep up with the latest research.

One of the best sources of the latest research is the government website, http://www.pubmed.gov. All you need do is type in one or two terms at the top search box and numerous studies will appear. At the very least, before accepting research findings as valid, be sure to check who is funding the study, that an adequate-sized and relevant population is used, and whether the outcomes are positive. Use only findings that are based on systematic study, not anecdotes or opinions.

The core foundation of health promotion is unchanging: Whatever the specifics of methods or evidence, the intent is always to assist clients—individuals, families, or communities—to obtain optimal health in all senses. Be it physical, mental, social, environmental, or spiritual, establishing a strong foundation for wellness is the cornerstone of health promotion practice.

Summary

Health may be defined from the viewpoint of caregivers and clients. Health and its determinants have been described since Florence Nightingale's *Notes on Nursing*. As infectious diseases were quelled, health started to attain a higher priority in society. Prior to World War II, emphasis was mainly on illness and disease. After the war, health concepts shifted to focus on maintaining not only the body, but the mind, the emotions, the family, and the community. Health began to be viewed as something the individual could affect through taking part in positive actions.

The World Health Organization (WHO) incorporated wholeness and positive qualities of health into its 1946 definition; by 1986, WHO had expanded its definition to include spiritual, psychological, and economic health as well as the ability to fulfill social roles. Later, concepts of wellness and global health were developed.

Smith (1983) described health within four dimensions, defined by extremes of the health–illness continuum: clinical dimension, role-performance dimension, adaptive dimension, and eudaimonistic dimension. In recent decades, mental illness and quality of life have become incorporated as inseparable to considerations of health. Your role is to help the client improve wellness in all dimensions.

Disease prevention is the avoidance of illness and agents of illness, plus identification of risks. Disease prevention may be categorized as primary, secondary, and tertiary prevention.

Primary prevention precedes disease and includes a set of actions that prevent a specific disease or condition. Secondary prevention is the identification and treatment of asymptomatic persons who have developed risk factors or are at a preclinical state. Tertiary prevention is the treatment and management of clinical and chronic disease, restoring the client to optimum function and maintenance of life skills. Leavell and Clark developed a conceptual map that outlines activities to be undertaken at each of the three levels of prevention.

Although health can be measured with clinical tools, wellness is self-assessed and self-evaluated. High-level wellness includes maximizing one's potential, having direction and purpose in life, meeting the challenges of the environment, looking beyond the needs of self to the needs of society, and doing it all with joy or a zest for life.

Health promotion has many definitions, most of which incorporate elements of well-being, quality of health, and avoidance of illness for individuals, families, and communities. Included under the concept of health promotion are health education, health protection, and disease prevention. Determinants of health may include a range of factors including social, economic, and environmental categories.

REVIEW QUESTIONS

1. What is quality of life?
   a. General well-being as assessed by either that individual or by another person about that individual
   b. A set of actions that prevents a specific disease or condition
   c. Activities that promote well-being
2. Primary prevention is
   a. Treatment and management of the patient's clinical and chronic disease
   b. Identification and treatment of asymptomatic persons who have developed risk factors
   c. A set of actions that prevents a specific disease or condition
3. Tertiary prevention is
   a. Treatment and management of the patient's clinical and chronic disease
   b. Identification and treatment of asymptomatic persons who have developed risk factors
   c. A set of actions that prevents a specific disease or condition
4. Health promotion includes the following:
   a. Management of chronic disease
   b. Assessment and treatment of new-onset disease
   c. Health education and disease prevention
5. The eudaimonistic dimension of Smith's health definition is
   a. The positive interaction among the physical, social, psychological, and spiritual aspects of the environment
   b. The ability to adapt positively to social, mental, and physiological change for health versus illness
   c. The ability of the person to perform social roles, including work and family, based on societal expectations
6. The adaptive dimension of Smith's health definition is
   a. The positive interaction among the physical, social, psychological, and spiritual aspects of the environment
   b. The ability to adapt positively to social, mental, and physiological change for health versus illness
   c. The ability of the person to perform social roles, including work and family, based on societal expectations
7. Primary prevention includes
   a. Case-finding measures and mass screenings
   b. Provision of hospital and community facilities for retraining and education to maximize use of remaining capacities
   c. Use of environmental sanitation

8. Secondary prevention includes
   a. Genetic counseling
   b. Attention to personal hygiene
   c. Adequate treatment to arrest disease process and prevent further complications and sequelae
9. Determinants of health refers to
   a. A range of factors, including social, economic, and environmental
   b. Case-finding measures and mass screenings
   c. General well-being
10. Nutbeam's list of factors that are determinants of health includes
    a. Adequate treatment
    b. Social support networks
    c. Work therapy in hospitals

EXERCISES

1. Explore the term *health*. Find dictionary definitions, discussions in textbooks, and links on the Internet. Read about nursing models and theories that discuss the concept of health.
2. Review the topic of disease prevention. Pick a special health-related issue or disease you are interested in and list the activities related to this issue or disease that could be categorized as primary prevention, secondary prevention, and tertiary prevention.
3. Go to the website http://www.nurses.info/nursing_theory_accepted_theories.htm Find a research instrument related to health or quality of life and briefly outline a study you might conduct using this instrument.
4. Find information about principles of health education. Apply these principles and devise a brief plan for patient education related to the issue or disease you identified in exercise No. 2.
5. Check out the following websites to learn more about primary, secondary, and tertiary prevention of skin and other cancers:

   http://www.cdc.gov/ChooseYourCover

   http://www.foundation.sdsu.edu/sunwisestampede/

   http://www.cancer.org

   http://www.cancer.gov

   http://www.preventcancer.org

   a. List at least two examples of skin or other types of cancer prevention at each of the prevention levels. Who would you target with each of the methods you described?
   b. Find out what your school or hospital setting is doing to protect people from the sun.
      - Have they built shade structures or planted trees?

- Do they encourage the use of hats and protective clothes when outside?
- Do they furnish sunscreen?

c. The Centers for Disease Control and Prevention (CDC) is active in developing policies and programs on sun exposure and protection. For its latest information, go to http://www.cdc.gov/cancer/skin/basic_info/prevention.htm What can you do with this information to help prevent skin cancer?

6. California recently passed a law that says California schools must let children wear sun protective clothes at school. Share information on the following issues with one of your classmates:
   a. What are your thoughts on the law?
   b. What kind of barrier was the law trying to overcome?
   c. Does your state or school have a law or rule that prevents you from wearing hats or wearing sunscreens?

7. Overweight/obesity is linked with numerous illness conditions. Losing weight is an important goal for a significant number of adults and children. Check out the following weight-loss websites:

   http://www.healthcastle.com/easy-weightloss.shtml

   http://diet.health.com/2009/12/22/crash-diets/

   - List two ways you could use this information with clients.
   - List two ways you could use this information with yourself, your family, or friends.

   Choose one wellness indicant as your goal for the next year; e.g., I will exercise for 1 hour a day by either riding a stationary bike or swimming, or I will reduce my stress by taking a yoga class and participating every week for 1 hour.

REFERENCES

Andrews, F. M., & Withey, S. B. (1976). *Social indicators of well-being*, (pp. 63–106). New York, NY: Plenum Press.

Baird, K. (2011). Inside the patient experience—Elizabeth's journey #10. Retrieved from http://baird-group.com/blog/inside-the-patient-experience-%E2%80%93-elizabeth%E2%80%99s-journey-10

Benyamin, R., Trescot, A. M., Datta, S., Buenaventura, R., Adlaka, R., Sehgal, N., . . . Vallejo R. (2008). Opioid complications and side effects. *Pain Physician, 11*(March; 2 Suppl), S105–S120.

Centers for Disease Control and Prevention [CDC]. (2011). *Health-related quality of life (HRQoL): Well-being concepts*. Retrieved from http://www.cdc.gov/hrqol/wellbeing.htm#three. Atlanta, GA: Centers for Disease Control and Prevention Health Related Quality of Life Surveillance Program.

Collins, E., Langbein, E., & Fehr, L. (2008). Can ventilation-feedback training against exercise tolerance in patients with chronic obstructive pulmonary disease. *American Journal of Respiratory and Critical Care Medicine, 177*(8), 844–852.

Diener, E. (2000). Subjective well being: The science of happiness and a proposal for a national index. *American Psychologist, 55*(1), 34–43.

Dix, K. L., Slee, P. T., Lawson, M. J., & Keeves, J. P. (2012). Implementation quality of whole-school mental health promotion and students' academic performance. *Child and Adolescent Mental Health, 17*(1), 45–51.

Donat, H., & Ozcan, A. (2007). Comparison of the effectiveness of two programmes on older adults at risk of falling: Unsupervised home exercise and supervised group exercise. *Clinical Rehabilitation, 21*(3), 272–283.

Dunn, H. (1961). *High level wellness*. Arlington, VA: Beatty Press.

Dwore, R. B. & Kreuter, M. W. (1980). Reinforcing the case for health promotion [Update]. *Family and Community Health*, *2*(4), 103–119.

Edburg, M. (2012). *Essentials of health, culture, and diversity: Understanding people, reducing disparities*. Burlington, MA: Jones & Bartlett Learning.

Furlan, A. D., Sandoval, J. A., Mailis-Gagnon, A., & Tunks, E. (2006). Opioids for chronic noncancer pain: A meta-analysis of effectiveness and side effects. *Canadian Medical Association Journal, 174*(11), 1589–1594.

Gore, M., Sadosky, A. B., Leslie, D. L., Tai, K. S., & Emery, P. (2012). Therapy switching, augmentation, and discontinuation in patients with osteoarthritis and chronic low back pain. *Pain Practice* (January 9). Advance online publication. doi:10.1111/j.1533-2500.2011.00524.x

Holdsworth, M., Gartner, A., Landais, E., Maire, B., & Delpeuch, F. (2004). Perceptions of healthy and desirable body size in urban Senegalese women. *International Journal of Obesity, 28*, 1561–1568.

Jamison, R. N., Serraillier, J., & Michna, E. (2011). Assessment and treatment of abuse risk in opioid prescribing for chronic pain. *Pain Research and Treatment*. 2011:941808. Retrieved from www.ncbi.nlm.nih.gov/pmc/articles/PMC3200070/

Kelly, F. J., & Fussell, J. C. (2011). Air pollution and airway disease. *Clinical and Experimental Allergy, 41*(8), 1059–1071.

Leavell, H., & Clark, A. (1965). *Preventive medicine for doctors in the community*. New York, NY: McGraw-Hill.

Manheimer, E., White, A., Berman, B., Forys, K., & Ernst E. (2005). Meta-analysis: Acupuncture for low back pain. *Annals of Internal Medicine, 142*(8), 651–663.

Maville, J., & Huerta, C. (2002). *Health promotion in nursing*. Albany, NY: Delmar Publishers.

Moritz, S., Liu, M. F., Rickhi, B., Xu, T. J., Paccagnan, P., & Quan H. (2011). Reduced health resource use after acupuncture for low back pain. *Journal of Alternative and Complementary Medicine, 17*(11), 1015–1019.

Murray, R., Zentner, J., & Yakimo, R. (2009). *Health promotion strategies through the life span*. Upper Saddle River, NJ: Pearson Education.

Nightingale, F. (1860). *Notes on nursing, What it is and what it is not*. London, England: Gerald Duckworth & Co.

Nutbeam, P. (1998). Health promotion glossary. *Health Promotion International, 13*(4), 349–364.

O'Donnell, M. P. (2009). Definition of health promotion 2.0: Embracing passion, enhancing motivation, recognizing dynamic balance, and creating opportunities. *American Journal of Health Promotion, 24*(1), iv.

Office of the Surgeon General. (1999). *Mental health: A report of the surgeon general*. Washington, DC: U.S. Department of Health and Human Services: Retrieved from http://www.surgeongeneral.gov/library/mentalhealth/chapter1/sec1.html

Parton, D. (2011). Living with stigma is still the common experience for mental health service users. *Mental Health Today*, (July–August), 5.

Pender, N., Murdaugh, C., & Parsons, N. (2006). *Health promotion in nursing practice* (5th ed.). Upper Saddle River, NJ: Pearson Prentice Hall.

Ramage-Morin, P. L., Shields, M., & Martel, L. (2010). Health-promoting factors and good health among Canadians in mid- to late life. *Health Reports/Statistics Canada, 21*(3), 45–53.

Rubenstein, L. Z. (2006). Falls in older people: Epidemiology, risk factors and strategies for prevention. *Age and Ageing, 35*(2 Suppl.), ii37–ii41.

Ryff, C. D., & Keyes, C. L. M. (1995). The structure of psychological well-being revisited. *Journal of Personality and Social Psychology, 69*(4), 719–727.

Smith, J. (1983). *The idea of health: Implications for the nursing profession*. New York, NY: Teachers College Press.

Smith, B. J., Tang, K. C., & Nutbeam, D. (2006). WHO health promotion glossary: New terms. *Health Promotion International, 21*(4), 340–345.

Stevens, J. A., & Olson, S. (2000). Reducing falls and resulting hip fractures in older women. *Morbidity and Mortality Weekly Report, Recommendations and Reports, 49*(March 31, RR-2), 3–12.

Thorn, B. E., Day, M. A., Burns, J., Kuhajda, M. C., Gaskins, S. W., Sweeney, K., . . . Cabbil, C. (2011). Randomized trial of group cognitive behavioral therapy compared with a pain education control for low-literacy rural people with chronic pain. *Pain, 152*(12), 2710–2720.

Trigkilidas, D. (2010). Acupuncture therapy for chronic lower back pain: A systematic review. *Annals of the Royal College of Surgeons of England, 92*(7), 595–598.

Von Korff, M., Kolodny, A., Deyo, R. A., & Chou R. (2011). Long-term opioid therapy reconsidered. *Annals of Internal Medicine, 155*(5), 325–328.

White, A. P., Arnold, P. M., Norvell, D. C., Ecker, E., & Fehlings, M. G. (2011). Pharmacologic management of chronic low back pain: Synthesis of the evidence. *Spine (Phila Pa 1976), 36*(October 1; 21 Suppl), S131–S143.

Wiseman, J., McLeod, J., & Zubrick, S. R. (2007). Promoting mental health and well-being: Integrating individual, organisational and community-level indicators. *Health Promotion Journal of Australia, 18*(3), 198–207.

World Health Organization. (1946). *Preamble to the Constitution of the World Health Organization*. Signed at the International Health Conference, New York, July 22, 1946.

World Health Organization [WHO]. (1948). *Constitution of the World Health Organization*. Geneva, Switzerland: Author. Retrieved from http://apps.who.int/gb/bd/PDF/bd47/EN/constitution-en.pdf

World Health Organization [WHO]. (1958). *The first ten years of the World Health Organization*. Geneva, Switzerland: Author.

World Health Organization [WHO]. (1986). *Ottawa Charter for Health Promotion*. First International Conference on Health Promotion, Ottawa, Canada, November 21, 1986—WHO/HPR/HEP/95.1.

INTERNET RESOURCES

For a full suite of assignments and learning activities, use the access code located in the front of your book to visit this exclusive website: **http://go.jblearning.com/healthpromotion**. If you do not have an access code, you can obtain one at the site.