

*Excerpted from*

PROMOTING  
HUMAN  
WELLNESS

New Frontiers for Research, Practice, and Policy

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**Margaret Schneider Jamner**

## **INTRODUCTION**

### *New Frontiers for Research, Practice, and Policy*

Wellness promotion, as this volume demonstrates, is at a critical juncture as we enter the new millennium. We have gained an appreciation for the complexity of the task and are beginning to develop methods for identifying the most effective strategies for improving the health-related quality of life among Americans. Moreover, we have expanded our sphere of influence to encompass not only the immediate causes of morbidity and mortality but also the more fundamental determinants that reside in the political, social, and physical environments. This volume illustrates the potential for promoting human wellness that has been generated by these developments. Future success in realizing this potential relies on recognizing that elements that are often encountered as barriers to health promotion (e.g., political agendas, idiosyncratic populations) can and must be embraced and incorporated into the methods that guide wellness research and practice. Only by employing these elements to serve the ends of wellness promotion will we sustain the current momentum toward creating a nation that supports and facilitates optimal health.

The chapters in this volume offer compelling evidence for the complex web of interrelated influences that operate dynamically to determine health and wellness. Regardless of the specific disease or disability being examined, it is clear that one must consider the likelihood that health status may be affected by variables at many levels, including (but certainly not limited to) the human genome, individual health behavior and psychological attributes, medical care, and the physical and social

environments. Moreover, each level has the potential to interact with factors from other dimensions. As described by Leonard Duhl (1996), “It is as if there were a ball of interconnected strands that could be picked up at any point, and a relationship to all other issues, institutions, people, and places would exist” (p. 259).

The multidimensional model that could be constructed to depict any specific health problem threatens to be overwhelming in its complexity. Nevertheless, conceptualizing wellness promotion from a systems perspective may turn out to be a requirement for effective intervention (Wandersman et al., 1996). It is important, therefore, to note that work presented in these pages also provides testimony that adopting a systems approach to wellness does not preclude elegant solutions to health problems and, in fact, may simplify matters by identifying optimally effective leverage points for intervention. In order to realize the potential within the systems approach for identifying parsimonious pathways to promoting health, it is crucial that health researchers, health practitioners, and policy makers maintain an exceptionally broad vision of the range of activities and targets that may fall within the health promotion mandate. It is equally important that wellness professionals address explicitly the nonscientific forces bearing on the translation of wellness knowledge into effective action.

Public health, the parent discipline to wellness promotion, has been said to permeate “through all the social, environmental, and other activities of populations” (Holland, 1997, p. 1645). Likewise, although the promotion of human wellness is often identified with orchestrating a change in lifestyle, such individual modifications “usually require some combination of educational, organizational, economic, and environmental interventions in support of change in both behavior and conditions of living” (Green et al., 1997, p. 125). Appropriate targets for change in the pursuit of enhanced health and wellness for a population therefore include elements within the individual, the social milieu, the physical environment, the medical care system, the economy, and the political arena. This point is vividly illustrated by the chapters in this volume, several of which present impressive evidence of the powerful force for change that results from directly addressing contextual factors.

### **WELLNESS PROMOTION AND THE POLITICAL CONTEXT**

A number of the authors featured in this volume argue that the influence of the political context on human wellness deserves greater attention. In

particular, the politicization of health-related issues often results in a markedly skewed allocation of resources with respect to research. Strohman (chapter 5), for example, opines that the share of research funds devoted to mapping the human genome is grossly out of proportion to the health benefits that this project is likely to deliver. His work suggests that far greater salutary outcomes might be expected to accrue to the population if sufficient funds were directed to mapping out the ways in which genes interact with their immediate (i.e., organismic) and distal (i.e., extraorganismic) environments to determine phenotypic expression. It is in the interest of the goals of health promotion that scientists make a concerted effort toward educating political decision makers regarding the connection that proposed health research initiatives have to the objective of improving the health of the population.

This advice should not be interpreted as a condemnation of basic research, whose relationship to the human condition may at times be obscure or difficult to discern. Basic research is and will continue to be of great importance since expanding our understanding of the mechanics of our world can serve us in many unforeseen and significant ways. Nevertheless, in a society characterized by limited resources for research, the way in which these resources are distributed should be continually reassessed in order to determine whether adjustments in the allocation are likely to result in greater health returns.

Another instance of value-driven political agendas leading to inequitable resource allocation is the greater emphasis placed on men, as compared to women, in health research. As discussed by Stanton et al. (chapter 22), the historical view of the female as the lesser “deviation” from the male norm has contributed to the disproportionate attention paid to men in health research. The nominal representation of women in the sciences and politics in the past also has helped maintain the illusion that important research questions could be adequately addressed through research on men only. Villablanca (chapter 23) reaffirms this pattern in the case of heart disease. Although coronary heart disease is the leading cause of death for both men and women, the latter have been largely excluded until recently from most heart disease prevention trials. In the last decade, a shift toward greater recognition of the health needs of women has occurred and has led to attempts at establishing greater gender equity in research. This new movement has fueled the Women’s Health Initiative, which will yield a wealth of data concerning the factors that influence the health and wellness of women. Wellness professionals would do well to note this apparently successful culmination to years of

campaigning for gender equity in research. Results of the current wave of health research directed at women's issues will provide valuable scientific information useful in promoting women's health. In order to continue the momentum toward a more equitable health research agenda at the national level, wellness professionals must find effective ways to supply their expertise to the political decision-making process.

Values-laden political priorities also play a large role in determining the allocation of resources among interventions designed to improve or enhance health. Hofmann (chapter 20) eloquently lays out the argument for providing teens with complete information concerning contraception, yet recent federal legislation provides funds for school-based sex education that teaches abstinence-only pregnancy prevention. Given the strength of the evidence against the utility of the abstinence-only approach, it appears that this legislation is based not on scientific knowledge but rather on the values of individuals, lobbyists, and organized voter groups expressed as political will. Similarly, Waldo and Coates (chapter 24) describe the failure of HIV prevention programs and attribute this lack of success to a political climate that, for example, blocks widespread use of needle exchange despite ample evidence that allowing drug users to receive sterile syringes in exchange for used needles reduces HIV transmission without increasing drug use. A resolution issued in 1998 by the Presidential Advisory Council on HIV/AIDS (American Public Health Association, 1998) rebuked the president and the secretary of health and human services for failing to remove the ban on using federal funds for needle exchange programs and stated that "tragically, we must conclude that it is a lack of political will, not scientific evidence, that is creating this failure to act."

The persistence of the "agrarian myth" (a pervasive belief in the salutary conditions of agricultural occupations) in the face of data concerning the health problems of agricultural workers represents another case of an area in which policy and legislation have lagged behind available scientific information. As explained by Schenker (chapter 21), current health and safety legislation designed to protect farmers and farm laborers in the United States is notably insufficient. For example, Schenker notes that rollover protectors for tractors have been legislated in Europe but not in the United States, even though they essentially eliminate rollover fatalities. These examples demonstrate that successful wellness promotion requires engaging the political process in a data-based evaluation of funding and legislative priorities and pushing for policies that have the

greatest likelihood for improving national health status by addressing the actual needs of the nation's constituent populations.

The theorem that the political context plays a large role as a force affecting how public health knowledge is translated into preventive action is generally acknowledged in the field of public health. In the first chapter of the 1997 edition of the *Oxford Textbook of Public Health*, Detels and Breslow state, "What can be done will be determined by the scientific knowledge and resources available. What is done will be determined by the social and political commitments existing at the particular time and place" (p. 3). One model of this process, proposed by Richmond and Kotelchuck (1983), posits three factors that contribute to the shaping of health policy: knowledge base, political will, and a social strategy. According to Richmond and Kotelchuck, the knowledge base refers to "the scientific and administrative data base upon which to make decisions." Thus, epidemiologic research, needs assessments, clinical trials, and other forms of intervention evaluations all contribute to this knowledge base that may be used to inform health policy decisions. How or even whether this information is used, however, depends greatly on the political climate.

In discussing the Richmond and Kotelchuck model, Atwood et al. (1997) address the example of preventive priorities in the United States with respect to tobacco control. They point out that, because of a lack of political will, the proportion of resources currently allocated to preventing tobacco use does not correspond to the magnitude of the toll that tobacco takes on human health. These authors suggest that public health researchers should pay greater attention to how their work may be used to shape health policy and should consider this issue as integral to the research planning process. Planning a research agenda with findings that will be useful in shaping health policy is certainly one way to increase the social validity of public health research (Geller, 1991), yet it would be unnecessarily restrictive to confine the spectrum of public health research to one that speaks directly to policy issues.

More to the point, the authors in this volume demonstrate that wellness professionals need not remain detached from the political arena; rather, they may be able to dramatically impact community health by mobilizing political will. In fact, it has been suggested that "one of health education's major supportive functions is to enhance self-confidence and provide the variety of skills needed by individuals and their communities to influence the policy-making process" (Tones, 1997,

p. 785). The enormous potential for enhancing the impact of wellness promotion activities through shaping political will is illustrated in the interventions described by Minkler and Wallack in this volume. At the neighborhood level, Minkler (chapter 13) demonstrates that residents of a high-crime neighborhood can be successfully mobilized to lobby for increased police protection and consequently create an environment that facilitates improved health behavior. Although the connection between community crime levels and individual health habits has not been clearly established, there is an intuitive link between, for example, a fear of walking in one's neighborhood and the likelihood of walking for exercise. Moreover, as the chapter by Sanders-Phillips (chapter 11) shows, there is evidence suggesting that being exposed to violence in one's community may induce negative psychological states (e.g., depression, hopelessness, ennui) that act as barriers to the establishment of a healthful lifestyle. The Violence Prevention Initiative (VPI) detailed by Wallack (chapter 19) offers a model of what can be accomplished via advocacy of public policy solutions to public health problems. The tools employed by the VPI toward the goal of reducing the widespread and easy availability of handguns to youth have included savvy use of a scientific and applied database, mobilization of a broad range of constituencies, and strategic use of the mass media. Coordination of these elements has resulted in a number of tangible results, including the passage of numerous local gun-control ordinances and statewide legislation (approved by the California State Legislature but later defeated by governor's veto) banning the sale and distribution of Saturday Night Specials.

The programs described by Minkler and Wallack are unique not only because they appear to succeed but also because they squarely address community-level issues that interfere with the "response-ability" of individuals to remain healthy. It is interesting to note that both of these programs are focused on violence. Whereas the VPI (Wallack) targets primarily potential perpetrators and victims of gun violence, the Tenderloin project (Minkler) addresses the indirect effects of living within a climate characterized by the threat of violence. Both programs, however, address the problem of violence through political influence exerted by members of the community. Together, these programs demonstrate that the future success of health promotion relies on a willingness both to tackle social problems that may in the past have been considered outside the domain of public health and to enlist political strategies in the process.

The focus on violence may reflect the growing concern of the American public with the problem of violent crime, a concern that has led to

such legislative developments as the “three strikes” law in California. It may be, therefore, that part of the success of these efforts should be attributed to a preexisting political climate that was hospitable to antiviolen­ce innovations. In this way, then, these programs exemplify how programmatic outcomes may be enhanced when the political climate is not hostile to the intent of the intervention. Recent California gun-related legisla­tive action in the wake of shooting incidents in school and day-care settings further demonstrates that when the political will is galvanized by immediate events, health-promoting legislation may be enacted quite rapidly.

### **WELLNESS PROMOTION AND INNOVATIVE METHODOLOGY**

In addition to mobilizing political will, another strategy with great potential for enhancing the translation of scientific expertise into wellness promotion is a greater reliance on nontraditional methods in both community and clinical settings. This point is made explicitly by Syme (chapter 4), who contrasts the success of *The Wellness Guide*, an intervention tool heavily influenced by qualitative research methods, with large-scale interventions such as MRFIT that were developed using a “top-down” methodology (i.e., expert driven). The idea that purveyors of health information should become familiar with the beliefs, attitudes, knowledge, and perceived needs of the populations they seek to reach is embodied in the tenets of social marketing (Novelli, 1990). Syme extends this approach to incorporate a consumer-driven perspective to selecting not only the method of intervention delivery but also the intervention content. Thus, the *Guide* that was eventually developed to meet the community’s needs actually contained relatively little “health” information. Evaluation of the *Guide* suggests that it was used by the recipients and resulted in significant cognitive and behavioral changes with implications for health. Similarly, the program described by Minkler (chapter 13) evolved as it did because elderly residents of an inner-city neighborhood were given the opportunity to shape the program. As a result, the investigator’s resources were directed toward assisting the residents in their efforts to reduce the threat of crime in their neighborhood. Although these programs do not conform to the traditional view of a health promotion intervention, they succeeded in the sense that they were embraced by the target communities, resulted in tangible improvements, and

facilitated beneficial behavior changes. These success stories offer considerable fuel to the imperative for wellness promotion professionals to step outside the boundaries of traditional public health paradigms and engage in greater attempts to obtain relevant information from the members of the communities that they seek to serve and to do so quite early during program development.

Innovative methods also can play an important role in program evaluation. Strong program evaluations are critical to the growth of community-based health promotion because they can both identify programs that work and provide clues about the reasons that some programs fail. Birckmayer and Weiss (chapter 7) provide a number of examples in their discussion of theory-based evaluation (TBE), in which the use of process evaluation contributes substantially to the interpretation of program evaluation results. Unlike traditional outcomes-only evaluations, documenting program activities in a process evaluation can permit evaluators to distinguish cases in which an intervention fails because of inadequate theory from cases in which an intervention fails because of inadequate program implementation. Since program evaluation remains a linchpin of wellness promotion, it is paramount that future interventions include this type of approach in order to facilitate effective program development.

Ganiats and Sieber (chapter 12), in their discussion of the complexity involved in attaching monetary values to future health outcomes, offer additional evidence in support of using nontraditional methodology in program evaluation. Policy analysts typically assign a numeric discounting rate to both dollars and health in conducting a standard cost-effectiveness analysis. Unfortunately, since most health promotion programs expend dollars in the present for health outcomes in the future, programs tend to fare poorly in these analyses. As Ganiats and Sieber point out, the value that an individual might place on a future health outcome can vary considerably, depending on personal characteristics and circumstances. Only through careful and population-specific studies is it possible to obtain useful estimates concerning how future health outcomes should be valued for a particular program. These authors suggest, therefore, that the qualitative dimension of time preferences with respect to future health outcomes needs to be better understood in order to permit useful comparisons of cost-effectiveness across programs.

Wellness promotion in the clinical setting also stands to gain from incorporating methods that transcend the traditional medical model. Slavin and Wilkes (chapter 17) address this topic from the perspective

of the training provided to physicians. In describing their innovative doctoring curriculum, they emphasize the value of a person-centered diagnostic approach in which physicians consider social facets of patients' health problems. They give the example of detecting domestic violence through patient-centered interviewing techniques and mobilizing community resources to address not only the immediate injury but also the potential for future injury. A person-centered (rather than a disease-centered) approach to medical treatment decisions also is encouraged by Duxbury (chapter 15), who reviews the pros and cons of screening for prostate cancer. The high probability for false positives in prostate cancer screening and the likelihood that quality of life will diminish following surgical intervention combine to argue against the ultimate benefit of screening to the patient. This conclusion rests, however, on the qualitative assessment of alternative treatment outcomes. In a broader discussion of health promotion strategies for the elderly, Beck (chapter 16) also favors a person-centered approach. Specifically, he describes a comprehensive preventive assessment for the elderly that takes into account physical, social, and medical resources and yields a prioritized set of recommendations. These recommendations go far beyond the typical physicians' advice and may include suggestions such as reducing or eliminating a medication, enrolling in a class at a community college, or installing shower rails for the handicapped.

Unlike the traditional biomedical model, which tends to reduce patients to a disease entity and focuses on isolating and eliminating the disease, the patient-centered approach put forth by these authors seeks to optimize functioning and well-being. In order to successfully achieve this goal, clinicians must include qualitative assessment methods in their diagnostic procedures and, similarly, must consider the impact of treatment on the patient as a whole being. This method of evaluating alternatives for patient treatment has been formalized in the General Health Policy Model (GHPM) described by Kaplan (chapter 3). The GHPM uses a standard metric, quality-adjusted life years (QALYs), to compare intervention strategies. Quality-adjusted life years are based on "the current life expectancy adjusted for diminished quality of life associated with dysfunctional states and the duration of stay in each state" (p. 50). A key component of the GHPM is generated by individuals drawn from the general population who rate various health outcomes according to their relative importance. In other words, laypersons assign relative values to a series of health outcomes in order to quantify their feelings about various states of disability. Consequently, treatment decisions

based on the GHPM are informed by the qualitative dimension of alternative outcomes. All the innovative approaches described by Slavin and Wilkes, Beck, Duxbury, and Kaplan consider the impact of medical intervention on the patient as a functioning person (rather than as a host to a disease) as a factor in treatment decisions. This humanistic framework offers great potential for maximizing patients' health in the face of disease. The future of wellness promotion as an aspect of medical care relies on the institutionalization of these types of innovative approaches in clinical settings.

### A MODEL INTERVENTION

The various interventions reported by Syme, Minkler, and Wallack, described previously, illustrate what may be accomplished when program planners are receptive to input from the target community and are willing to engage in activities outside the parameters of what has traditionally been considered health promotion. Similarly, The Smokers' Helpline, a smoking cessation program detailed by Zhu and Anderson (chapter 14), represents a novel intervention that is based on extensive qualitative study of the target population. In addition, the Smokers' Helpline has achieved a unique hybridization of the clinical approach with the public health approach to give rise to a highly efficacious—and effective—program.

The Helpline is unusual in several ways. The menu of services offered to smokers who call the Helpline is one key element to the marriage between a population-based reach (the public health approach) and intensive one-on-one treatment (the clinical approach). Also critical is the proactive strategy in which Helpline counselors follow up on initial calls rather than waiting for smokers to call back to begin counseling. A third component that distinguishes the Helpline is the scheduling of counseling sessions such that more sessions occur during the time with the greatest probability of relapse. The availability of counseling in several languages contributes as well to the Helpline's success. Ultimately, of course, dissemination of the Helpline's toll-free numbers is critical and has been accomplished by including the numbers in ads funded by the Tobacco Control Section of the California Department of Health and by establishing partnerships with primary care physicians.

Although not explicitly, the Smokers' Helpline also acts as a model of a health promotion intervention that works within the political con-

text to further its effectiveness. As explained by Zhu and Anderson, the Helpline was funded through the monies generated by Proposition 99, the California Tobacco Tax Initiative. This proposition was an expression of Californians' support for interventions that would reduce the health threat of tobacco use. Unlike the effort to restrict public smoking, however, the Helpline has not encountered organized political resistance. Very likely, this tacit acceptance stems from the congruence between the conservative point of view that individuals should take responsibility for their own health and behavior and the Helpline's focus on assisting smokers in their own attempts to quit. Even the tobacco industry would be hard-pressed to muster an argument against providing smokers with assistance toward quitting. Consequently, the Helpline has enjoyed a sort of political immunity that has provided room for its growth and success.

### **WELLNESS PROMOTION AND INTERVENTION LEVERAGE POINTS**

A number of the chapters presented in this volume exemplify an approach to promoting human wellness based on the strategy of identifying high-impact leverage points for intervention. In this approach to health promotion, the goal is to identify and make use of "certain behaviors, social roles, and situational conditions [that] can exert a disproportionate influence on personal and collective well-being" (Stokols, 1996, p. 291). East (chapter 8) identifies one such high-impact leverage point in her discussion of the increased risk for pregnancy among younger sisters of childbearing teens. Specifically, she explains how both the indirect effect generated by sisters' shared family and community environment and the direct effect on younger sisters of having an older sister with a child (e.g., orientation to child-rearing, witnessing of social status attributed to the older sister) combine to place younger sisters of childbearing teens at elevated risk for teen pregnancy. East's research points to the potential impact on teen pregnancy rates that might be brought about through interventions targeting these younger sisters of childbearing teens.

In a somewhat different approach to identifying potential leverage points for health promotion, Guendelman (chapter 9) identifies attributes that may bring about desirable birth outcomes among immigrant mothers. She first describes a paradox wherein immigrants from Mexico and Southeast Asia experience more favorable birth outcomes than

would be expected on the basis of their socioeconomic status. She posits that these surprising findings may reflect health-promoting cultural factors, including salutary dietary habits, strong social cohesion, and relatively low substance abuse. Guendelman's approach suggests that wellness promotion should focus not only on intervening to reduce risk factors for disease but also on encouraging attributes associated with more positive health outcomes.

Like Guendelman, Roach (chapter 10) employs an analysis of epidemiologic data to explore an issue of inequity in health outcomes. In this case, the focus is on disentangling the influence of race from that of environmental and behavioral factors associated with race. Through his examination of differential cancer mortality in Blacks versus Whites, Roach calls into question the medical community's adherence to certain disease categorization systems that may mask differences in the extent of disease on diagnosis by a physician. Roach's scrutiny of the data suggests that, by using a grouping scheme that does not differentiate finely enough between stages of cancers, researchers and clinicians may be overlooking the underlying reasons for greater cancer mortality among Blacks. The implication of Roach's argument is that identification of effective leverage points for ameliorating the cancer epidemic will require altering current clinical diagnostic categories and looking beyond race to modifiable variables that may increase the risk of dying from cancer. The more general lesson to be taken from Roach's argument is that clinical diagnostic categories may artificially obscure important differences between patients and that these differences may provide clues for primary or secondary disease prevention.

Another technique for promoting wellness through identifying critical leverage points is to specify a particular context within which individuals may be affected by an intervention and then design a program for that context. Nader offers an example of this strategy in his description of the school-based CATCH intervention (chapter 18). Schools often have been put forth as locales within which children may be reached and effectively influenced to enhance their health. Nader adds to this traditional perspective the proposition that partnerships between universities and schools yield mutually beneficial avenues for promoting children's health. Such partnerships can offer valuable field experience to university students, supply meaningful data to university-based researchers, and bring about positive changes in behavior among schoolchildren. Thus, the partnership between the university and schools may be a potent leverage point both for improving community health directly and

for enhancing the education of individuals who will be in a position to influence community health at the conclusion of their training.

## CONCLUSIONS

Whether addressing the question of who should be targeted, what to target, or where an intervention should be delivered, identifying optimal leverage points should be a priority in wellness promotion. It has been suggested, for example, that the primary task for those interested in promoting human wellness is to “set up the conditions that optimize health . . . [including] such naively elementary ideas as abolishing war, meeting basic needs (not wants) and redistributing the wealth of the planet” (Duhl, 1996, p. 261). More specifically, Syme (chapter 4) states that the most critical factors related to health are problems of inequity and that, therefore, all available energy should be devoted toward minimizing the unequal distributions of resources within the society of the United States. This goal is perhaps so daunting to most individuals that it may induce a sense of helplessness. In fact, however, there are many specific instances of inequity in American society that appear more vulnerable to influence when viewed independently. Access to health care services is one issue frequently mentioned in discussions of inequity and health. Many factors contribute to the fact that some people have greater and easier access to health care than others. Lack of insurance, transportation, child care, or language skills are but a few of the barriers that can prevent individuals from receiving health care. These impediments are very real and quite prevalent. Nevertheless, one example in this volume—the Smokers’ Helpline—demonstrates a program in which all these problems have been minimized. The smoking cessation program is funded through cigarette tax dollars, thus eliminating the need for health insurance. The program is administered via telephone, which does away with the need for transportation or child care. Finally, the service is available in several languages to accommodate non-English speakers and allow some tailoring to specific cross-cultural concerns, such as issues of confidentiality. It would be naive to suggest that similarly elegant solutions could be found for the great host of health care services that are available to some and not to others. Still, it is encouraging to note that in at least one case technology, legislation, and innovative programming have been synthesized into a service that is available free of charge to the great majority of California residents.

The present volume aims to stimulate progressive action in the wellness field that speaks to the several themes outlined in this introduction (i.e., consideration of the political context and mobilization of political will, deployment of nontraditional assessment and intervention strategies, and identification and appropriate exploitation of high-impact leverage points). There are a number of specific topic areas both within and outside the sphere of traditional public health that are not covered in this collection and that have clear implications for health. For example, there are dramatic contrasts in the quality of schooling provided to the nation's youth. Since education level is quite strongly predictive of various health behaviors as well as of overall health status, it would be appropriate for those interested in improving the health of Americans to turn attention toward equalizing educational opportunities. Other areas that are not featured in this volume include work-site health promotion, unintentional injuries (e.g., vehicular accidents), and substance abuse. The reader should bear in mind that this volume is not intended to be a comprehensive review of the wellness field; rather, it attempts to motivate innovation within the field by drawing attention to topics that have received inadequate attention by wellness researchers and practitioners until now.

This introduction has attempted to highlight some of these previously underemphasized themes. The necessity of adopting a systems perspective toward wellness promotion, the value added by innovative assessment strategies, and the utility of considering political influences as a force in health promotion are acknowledged in these pages by physicians, sociologists, psychologists, biomedical researchers, and those whose training is grounded in the field of public health. That so many disparate disciplines find common ground with regard to wellness promotion is further evidence that the complex web that defines the field reaches into multiple academic domains and requires an interdisciplinary effort to understand the relevant issues and devise appropriately elegant solutions. It should therefore not be surprising that the varied works presented here do in fact share a great deal of overlap in terms of the underlying messages regarding using a multifactorial approach to wellness, examining wellness issues in context, and targeting intervention points that are maximally effective. With these tenets as guidelines, the future of human wellness promotion promises to be replete with innovative solutions to old problems, with rapid responses to new problems, and with greater synergy between existing strategies for coping with ongoing problems. The current trajectory of the field thus holds great potential for improving the health of our nation and its constituent populations.

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