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RESEARCH ARTICLE

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Integral Well-Being Education for Mental Health Promotion: An Eight-Dimensional Preventive Framework for Behavioral Health and Human Flourishing

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ABSTRACT

Mental health has become one of the defining public health challenges of the twenty-first century. The global burden of mental disorders, the persistence of treatment gaps, the social and economic consequences of distress, and the growing complexity of digital, occupational, relational, and financial stressors all indicate that clinical response alone is insufficient. This article proposes Integral Well-Being Education as a preventive, multidimensional, and human-centered framework for mental health promotion, behavioral health, and human flourishing. The article is structured as a conceptual review and framework paper based on a purposive synthesis of literature from global mental health, positive psychology, behavioral health, lifestyle medicine, social determinants of health, arts and health, workplace well-being, financial stress, and digital well-being. The proposed framework organizes well-being education into eight interdependent dimensions: body, thought, emotions, transcendence and meaning, social relationships, professional and vocational life, financial balance, and technology and digital life. The article argues that these dimensions constitute teachable domains of preventive mental health literacy and behavioral competence. The model is not presented as a substitute for psychiatric, psychological, or medical care; rather, it is proposed as a complementary educational architecture capable of strengthening protective factors, reducing behavioral vulnerability, supporting self-regulation, and promoting more coherent life habits across educational, organizational, community, and public health settings. The paper clarifies the model's theoretical contribution, differentiates it from established flourishing frameworks, proposes implementation pathways, identifies evaluation indicators, and discusses ethical safeguards and future research directions. Its central thesis is that mental health promotion requires not only services for illness, but also education for living: an integral, evidence-informed, and culturally adaptable approach that helps people develop the competencies needed to live with greater awareness, balance, dignity, connection, purpose, and responsibility.

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Introduction

Mental health is no longer a marginal theme within public health, education, or organizational life. It has become one of the major indicators of whether contemporary societies are able to protect human dignity, social cohesion, and sustainable development. The World Health Organization (WHO) has reported that in 2021 nearly one in every seven people worldwide, approximately 1.1 billion people, were living with a mental disorder, with anxiety and depressive disorders among the most common [1]. The WHO's World Mental Health Report also emphasized that mental health needs remain high while responses are often insufficient, fragmented, delayed, or inaccessible [2].

These figures reveal more than a clinical challenge. They reveal a cultural, educational, and behavioral challenge. Many mental health systems are still organized around late response rather than early prevention, around symptoms rather than life conditions, and around specialized services rather than shared social responsibility. Clinical care remains indispensable, particularly for people with severe distress, trauma, psychiatric disorders, or risk of self-harm. However, the scale and complexity of the challenge require a broader strategy that also educates people, families, schools, workplaces, and communities in the competencies that sustain mental health before suffering becomes chronic or disabling.

The Lancet Commission on global mental health and sustainable development argued that the global mental health agenda should move beyond the reduction of the treatment gap and include the promotion of mental health for entire populations [3]. This broadened view is consistent with the WHO's emphasis on mental health promotion and prevention, social determinants, community-based care, and action across sectors [2,4,5]. It is also consistent with behavioral health perspectives

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that examine how daily habits, environments, relationships, decisions, and routines shape psychological outcomes.

The central thesis of this article is that mental health promotion requires Integral Well-Being Education. People are not only biological organisms, cognitive systems, emotional beings, workers, consumers, family members, citizens, or digital users. They are all of these at once. Their mental health is influenced by their sleep, body, interpretation of reality, emotional literacy, sense of meaning, relationships, work, financial stress, and digital life. A preventive model that ignores any of these domains risks becoming partial, fragmented, or too abstract to be translated into everyday behavior.

This article proposes an eight-dimensional preventive framework for behavioral health and human flourishing. The model includes body, thought, emotions, transcendence and meaning, social relationships, professional and vocational life, financial balance, and technology and digital life. Its purpose is not to create another isolated theory of happiness, but to organize the main domains of human functioning into teachable, assessable, and behaviorally oriented areas of well-being education.

The article is written as a conceptual review and framework paper. It does not report an empirical trial and does not claim clinical validation of the model. Rather, it develops a theoretically grounded, evidence-informed, and hypothesis-generating framework that can be refined and tested through future research.

Methodological Approach

This manuscript follows the logic of a narrative conceptual review. It draws upon a purposive synthesis of literature rather than a systematic review protocol. The aim is not to exhaustively identify all empirical studies in each area of well-being, but to integrate convergent lines of evidence from several relevant fields into a coherent preventive framework for mental health promotion.

The conceptual synthesis was guided by five criteria. First, sources were selected for relevance to mental health promotion, prevention, behavioral health, well-being, or human flourishing. Second, priority was given to authoritative global reports, peer-reviewed reviews, meta-analyses, and widely cited theoretical frameworks. Third, the review included fields that are often treated separately, including positive psychology, lifestyle medicine, emotional education, social connection, occupational mental health, financial stress, digital well-being, and arts and health. Fourth, the model was designed to be educational rather than clinical, meaning that its core unit of intervention is not diagnosis but life competence. Fifth, the framework was developed with ethical caution: it is presented as complementary to professional care, not as a replacement for psychiatry, psychology, psychotherapy, or social services.

Because the model integrates diverse domains, this article uses conceptual triangulation. It compares the proposed framework with established models such as subjective well-being [6], psychological well-being [7], flourishing and PERMA [8], self-determination theory [9], salutogenesis [10], social determinants of mental health [4] and behavioral change theory [11]. The article then translates this synthesis into a practical eight-dimensional map.

Mental Health Promotion as Preventive Education

Mental health promotion is frequently misunderstood as a secondary activity, as if it were merely an inspirational supplement to clinical treatment. This is a mistake. Mental health promotion is a primary public health strategy. It seeks to create conditions in which individuals and communities can develop psychological resources, social support, emotional regulation, healthy habits, dignity, meaning, and agency.

Prevention in mental health can be understood across several levels. Primary prevention seeks to reduce risk factors before disorders emerge. Secondary prevention seeks early detection and timely intervention. Tertiary prevention seeks to reduce disability, relapse, or chronic suffering. A fourth dimension, which may be called promotive prevention, seeks to strengthen positive mental health, flourishing, resilience, meaning, and relational capacity. Integral Well-Being Education belongs primarily to the first and fourth levels, while remaining useful as a complement to secondary and tertiary care.

Behavioral health is a key bridge between prevention and daily life. Mental health is affected by what people repeatedly do: how they sleep, eat, move, think, relate, work, spend, consume media, use screens, and interpret adversity. These behaviors are not merely individual choices. They are shaped by culture, inequality, family patterns, work demands, technology design, urban environments, and social norms. Nevertheless, education can help individuals and institutions recognize modifiable patterns and create healthier conditions.

The OECD has emphasized that mental health promotion and prevention require school and workplace programs, mental health literacy, early detection, help-seeking, and suicide prevention as priorities for stronger mental health systems [12]. This reinforces the argument that education is not peripheral; it is part of the mental health infrastructure of a society.

An educational approach must also avoid reductionism. Teaching people to live better does not mean blaming them for suffering. It means offering practical, ethical, and evidence-informed resources for agency while recognizing structural constraints, trauma, poverty, discrimination, and the need for specialized support. Well-being education must empower without moralizing.

Theoretical Foundations

Positive Mental Health and Flourishing

The scientific study of well-being has progressively moved beyond the absence of illness. Diener et al. [6] helped consolidate subjective well-being as a legitimate area of psychological research, including life satisfaction and affective balance. Ryff [7] emphasized psychological well-being through autonomy, environmental mastery, personal growth, positive relations, purpose in life, and self-acceptance. Keyes [13] proposed a continuum from languishing to flourishing, showing that the absence of mental illness is not equivalent to the presence

of mental health. Seligman [8] proposed the PERMA model, organizing flourishing around positive emotion, engagement, relationships, meaning, and accomplishment.

Integral Well-Being Education is aligned with these traditions, but it has a different purpose. It does not aim to replace existing theories of flourishing. It aims to translate the promotion of mental health into a multidimensional educational architecture that can be taught, adapted, implemented, and evaluated across contexts. In this sense, the model is closer to an educational and preventive map than to a purely theoretical construct.

Salutogenesis and Sense of Coherence

Antonovsky's salutogenic model asked why people remain healthy despite stressors and adversity. Its central concept, sense of coherence, includes comprehensibility, manageability, and meaningfulness [10]. This approach is highly relevant to mental health promotion because it shifts attention from pathology alone to resources, coherence, and life orientation.

The eight-dimensional framework proposed here follows a similar preventive logic. It asks: what should people learn in order to understand their lives better, manage their resources more effectively, and find meaning in their choices and difficulties? Body, thought, emotions, meaning, relationships, work, money, and technology are not decorative themes. They are domains through which coherence is either strengthened or eroded.

Self-Determination, Agency, and Behavioral Change

Self-determination theory emphasizes autonomy, competence, and relatedness as basic psychological needs [9]. These needs are central to any preventive education model. People are more likely to sustain healthy behaviors when they experience them as meaningful, self-endorsed, socially supported, and compatible with their identity.

Behavior change theory adds an implementation perspective. The transtheoretical model, for example, recognizes that change usually occurs through stages rather than through instant insight [11]. Integral Well-Being Education therefore cannot be limited to lectures or information. It requires progressive learning, habit formation, reflective practice, social reinforcement, and environmental redesign.

Social Determinants and Relational Health

Social determinants of mental health include socioeconomic conditions, education, employment, housing, discrimination, gender, social support, safety, and access to resources [4]. These determinants remind us that mental health is not produced inside the individual alone. It is shaped by the conditions in which people are born, grow, learn, work, love, age, and participate in society.

Social connection has also become a major public health concern. The U.S. Surgeon General's advisory on loneliness and isolation described social disconnection as a profound health challenge with consequences for individuals, workplaces, schools, and communities [14]. Therefore, any serious model of well-being education must include relational competence and community belonging.

Arts and Transformative Learning

The arts offer a valuable pathway for well-being education because they integrate emotion, body, imagination, symbolic meaning, narrative identity, empathy, and shared experience. The WHO scoping review by Fancourt and Finn [15] synthesized evidence on the role of the arts in health and well-being, including prevention, promotion, management, and treatment. Arts-based learning can help people express what they cannot yet conceptualize, explore difficult emotions, build empathy, and transform experience into meaning.

In the present framework, art is not treated as entertainment or decoration. It can function as a pedagogical mediator: a way to activate emotional awareness, embodied learning, reflective distance, and social connection. This is especially relevant in mental health promotion, where purely cognitive instruction may not reach the deeper affective and relational layers of human experience.

Contribution of the Eight-Dimensional Model

The main contribution of Integral Well-Being Education is integrative and translational. Established well-being models offer powerful theoretical constructs, but many educational, organizational, and community programs still struggle to transform those constructs into daily habits and interdisciplinary curricula. The eight-dimensional model seeks to bridge that gap.

The model differs from PERMA by explicitly including body, financial balance, and technology as core domains of mental health promotion. It differs from purely lifestyle-based approaches by integrating meaning, emotions, relationships, and professional purpose. It differs from narrow mental health literacy programs by extending beyond knowledge of symptoms and services toward competencies for everyday living. It differs from isolated emotional education programs by recognizing that emotional regulation is deeply affected by sleep, financial stress, work culture, social connection, digital exposure, and meaning.

The model's originality lies in its architecture: it organizes the complexity of human life into eight educational dimensions that can be taught separately but interpreted systemically. A person's anxiety may be connected to thought patterns, but also to sleep, financial insecurity, loneliness, work overload, lack of meaning, or digital hyperstimulation. A preventive educational model must help people map these interdependencies instead of reducing distress to one cause.

The Eight Dimensions of Integral Well-Being Education

Body: The Embodied Foundation of Mental Health

The body is the first territory of well-being. Mental life is embodied. Sleep, nutrition, physical activity, breathing, inflammation, pain, fatigue, and somatic awareness all influence mood, attention, energy, and emotional regulation. A preventive model of mental health that ignores the body risks becoming overly cognitive and detached from daily experience.

Table 1: Eight-dimensional structure of Integral Well-Being Education.

Dimension	Core literacy	Behavioral mechanism	Protective function	Possible indicators
Body	Understanding physical needs	Sleep, movement, nutrition, recovery	Physiological regulation and energy	Sleep quality, physical activity, fatigue
Thought	Understanding mental narratives	Cognitive flexibility, attention, reframing	Reduced rumination and rigid interpretation	Perceived stress, cognitive flexibility
Emotions	Recognizing and regulating feelings	Emotional labeling, expression, tolerance	Emotional regulation and self-compassion	Emotion regulation, anxiety, depressive symptoms
Meaning	Clarifying values and purpose	Reflection, service, gratitude, hope	Existential resilience	Purpose in life, meaning, hope
Relationships	Building healthy connection	Empathy, boundaries, conflict resolution	Belonging and social support	Social connectedness, loneliness
Professional life	Working with dignity and purpose	Balance, psychological safety, vocational coherence	Burnout prevention and engagement	Burnout, work engagement, job satisfaction
Financial balance	Managing money and stress	Planning, conscious consumption, self-efficacy	Reduced financial anxiety	Financial stress, perceived control
Technology	Using digital tools consciously	Attention management, limits, digital rest	Reduced hyperstimulation and comparison	Screen habits, sleep, digital well-being

Evidence increasingly supports the relevance of lifestyle factors for mental health. A 2024 systematic review and network meta-analysis in The BMJ reported that exercise showed moderate effects for depression, with effects related to intensity and with several forms of exercise demonstrating benefit [16]. This does not mean that exercise replaces clinical care, but it does support the idea that physical activity is a meaningful part of mental health promotion and behavioral health.

Body education should include sleep hygiene, movement, nutrition awareness, breathing, relaxation, body respect, rest, and prevention of sedentary behavior. It should not promote perfectionism, body shame, or aesthetic pressure. The aim is to help people listen to the body as a source of information and care. The body should be understood not as a machine to exploit, but as the living base of psychological balance.

Thought: Cognitive Awareness and Interpretive Flexibility

Thought is the architecture through which people interpret reality. Cognitive patterns shape emotions, choices, relationships, and self-concept. Catastrophizing, rumination, rigid beliefs, selective attention to threat, and harsh self-criticism can intensify psychological suffering. Cognitive awareness is therefore a central domain of preventive education.

This dimension does not require turning every person into their own therapist. It requires teaching basic cognitive literacy: recognizing automatic thoughts, distinguishing thoughts from facts, identifying recurring narratives, questioning extreme interpretations, and cultivating more flexible ways of understanding experience. Cognitive flexibility can create space between stimulus and response.

Thought education also includes attention management. In a context of information overload and digital distraction, attention has become a psychological resource that must be protected. The ability to concentrate, reflect, pause, and decide is increasingly relevant to mental health.

Emotions: Literacy, Regulation, and Compassion

Emotional life is central to mental health. People often suffer not only because they feel intensely, but because they have not learned how to recognize, name, understand, express, and regulate what they feel. Emotional illiteracy may convert sadness into isolation, fear into avoidance, anger into aggression, and shame into silence.

Emotional education should include vocabulary, self-observation, emotional labeling, tolerance of discomfort, expression, self-compassion, grief literacy, anger management, anxiety management, and communication. It should teach that emotions are neither enemies nor absolute truths. They are signals that require interpretation, care, and sometimes action.

Compassion is especially important. Compassion does not mean sentimentality or lack of rigor. It means the capacity to recognize suffering and respond with care and responsibility. In preventive mental health, compassion can reduce shame, support help-seeking, and strengthen relational trust.

Transcendence and Meaning: Purpose as a Protective Factor

Human beings need meaning. Transcendence in this framework does not necessarily refer to religion, although it can include spiritual life for those who experience it. It refers more broadly to the capacity to live beyond immediate impulse, ego, consumption, or survival. It includes purpose, values, hope, gratitude, ethical reflection, service, and legacy.

Meaning can help people endure adversity, organize priorities, and transform suffering into learning. A lack of meaning may intensify emptiness, cynicism, despair, or existential fatigue. Preventive well-being education should therefore help individuals clarify what matters, what they serve, what they are willing to protect, and what kind of life they want to build.
Purpose education must be pluralistic and culturally sensitive. It should not impose a single worldview. Instead, it should invite reflection on coherence between values, choices, relationships, and actions. Mental health promotion is strengthened when people are not only taught to reduce symptoms, but also to live with direction.

Social Relationships: Connection, Belonging, and Relational Competence

Human beings are relational. Connection, belonging, affection, recognition, trust, and mutual care are protective factors for mental health. Loneliness and isolation, by contrast, can increase vulnerability and reduce resilience. The public health relevance of social connection has become increasingly visible in recent years [14].

Relational well-being education should include communication, empathy, assertiveness, conflict resolution, boundaries, forgiveness, family dialogue, friendship, community participation, and prosocial behavior. These competencies are not merely social skills; they are mental health resources.

In societies marked by acceleration, individualism, digital substitution of presence, and fragmented communities, learning to relate better is a preventive intervention. To live better is not only to feel better individually. It is also to connect better, listen better, repair better, and participate better.

Professional and Vocational Life: Work, Dignity, and Burnout Prevention

Work is one of the central determinants of adult well-being. It can provide income, identity, structure, belonging, recognition, learning, and purpose. It can also generate stress, injustice, exhaustion, alienation, moral distress, and burnout. For many adults, mental health cannot be understood without understanding work.

Occupational well-being education should include vocational purpose, healthy productivity, psychological safety, leadership with dignity, boundaries, recovery, feedback, career development, and prevention of burnout. The OECD has repeatedly emphasized the social and economic implications of mental ill-health for work, employment, productivity, and inclusion [12,17].

Organizations should not reduce mental health promotion to isolated workshops or crisis protocols. They should build cultures where people can work with dignity, autonomy, recognition, and meaning. Professional well-being is not only an individual responsibility; it is also a leadership and organizational responsibility.

Financial Balance: Money, Stress, and Psychological Security

Financial stress is a powerful source of anxiety, family conflict, shame, sleep disturbance, and psychological burden. Well-being education cannot ignore money. Financial balance does not mean wealth accumulation as an ultimate measure of success. It means developing a healthier relationship with resources, needs, debt, consumption, planning, uncertainty, responsibility, and self-efficacy.

Research has associated financial stress and hardship with poorer mental health outcomes, including depression and psychological distress [18]. The relationship can be bidirectional: mental health difficulties may reduce earning capacity or decision-making, while financial insecurity may increase worry and distress. A preventive model must therefore include financial literacy and financial emotional literacy.

This dimension should teach budgeting, conscious consumption, debt prevention, emergency planning, communication about money, and recognition of the emotions attached to financial life. Money is not only a technical matter. It is also psychological, relational, cultural, and moral.

Technology and Digital Life: Attention, Boundaries, and Human-Centered Use

Technology has become a psychological environment. Digital devices influence attention, sleep, self-image, relationships, learning, work rhythms, consumption, and emotional regulation. The question is not whether technology is good or bad. The question is whether people have the education necessary to use it consciously.

The U.S. Surgeon General's advisory on social media and youth mental health concluded that the evidence does not allow society to conclude that social media is sufficiently safe for children and adolescents and called for action to mitigate potential harms [19]. Although the advisory focuses on youth, the broader issue affects adults as well: digital life increasingly shapes comparison, attention, rest, presence, and identity.

Digital well-being education should include attention management, social media literacy, digital boundaries, cyberbullying prevention, sleep protection, online identity, digital rest, and human-centered artificial intelligence. Technology should serve human life rather than colonize it. Mental health promotion in the twenty-first century requires digital self-regulation.

Integrative Mechanisms of the Model

The eight dimensions are not separate compartments. They interact through several cross-cutting mechanisms that explain why the model should be implemented systemically.

First, self-awareness is the entry point of change. People cannot transform what they do not recognize. Awareness of body signals, thought patterns, emotional states, relational habits, work rhythms, financial stressors, and digital routines allows individuals to identify where imbalance is emerging.

Second, self-regulation translates awareness into action. Mental health promotion requires the capacity to regulate sleep, impulses, emotions, attention, consumption, communication, spending, work intensity, and digital exposure. Self-regulation is not repression; it is guided agency.

Third, meaning-making gives direction to behavior. Habits are more sustainable when they are connected to values, identity, and purpose. People are more likely to protect their health when they understand why it matters.

Fourth, social connection provides support and accountability. Behavior changes are more sustainable when reinforced by relationships, teams, families, and communities.

Table 2: Logic model for Integral Well-Being Education.

Input	Educational process	Intermediate outcomes	Long-term aims
Eight domains of life; evidence-informed content; trained facilitators; supportive settings	Psychoeducation; reflective practice; arts-based learning; habits; group dialogue; implementation plans	Mental health literacy; self-awareness; emotional regulation; healthier routines; social connection; help-seeking	Reduced vulnerability; resilience; flourishing; dignified work; digital balance; community well-being
Schools	Curricular modules, teacher training, peer activities	Emotional literacy, purpose, digital responsibility	Healthier developmental trajectories
Workplaces	Leadership programs, well-being audits, team rituals	Burnout prevention, psychological safety, engagement	Human-centered organizational cultures
Communities	Accessible workshops, family programs, arts and culture	Belonging, loneliness reduction, empowerment	Preventive public health culture

Fifth, habit formation turns insight into life. Well-being is not built by understanding alone. It requires repetition, routines, environmental design, and gradual consolidation.

Sixth, institutional culture either supports or undermines individual well-being. Schools, workplaces, families, and communities can either normalize exhaustion, comparison, silence, and isolation, or they can cultivate care, dignity, reflection, and connection.

Implementation Pathways

Schools and Universities

Educational institutions are privileged settings for prevention. They reach people before many patterns become deeply consolidated. Integral Well-Being Education can be implemented as a transversal curriculum, a modular program, or a set of integrated competencies across existing subjects.

In schools, the model can support emotional literacy, body awareness, digital responsibility, friendship, conflict resolution, meaning, healthy habits, and help-seeking. In universities, it can address stress, identity, loneliness, professional orientation, financial autonomy, and digital overload. Teacher well-being must also be central: institutions cannot teach well-being credibly if educators are exhausted, unsupported, or ignored.

Workplaces and Organizational Development

Workplaces can apply the model through leadership development, burnout prevention, psychological safety, financial well-being initiatives, digital balance policies, and rituals of recognition and recovery. The model offers an integrated map for organizations that want to move beyond fragmented well-being actions.

An organization may, for example, combine body-related initiatives such as sleep and recovery education with emotional literacy, manager training, team dialogue, purpose alignment, financial well-being support, and digital boundaries. The strength of the model lies in its capacity to connect these actions into a coherent culture of care.

Community and Public Health Programs

Community centers, municipalities, associations, libraries, cultural institutions, and public health programs can adapt the framework for accessible prevention. Community implementation is especially relevant for loneliness, older adults, caregivers, unemployment, youth transitions, and social vulnerability.

Arts-based formats may be particularly useful in community settings because they reduce stigma and invite participation through shared experience rather than clinical labeling. Theatre, music, visual arts, writing, and storytelling can facilitate emotional expression, connection, and meaning.

Clinical and Psychosocial Complementarity

The model may also complement clinical and psychosocial care. It can provide psychoeducational modules for people receiving therapy, recovering from burnout, managing chronic stress, or rebuilding routines after crisis. However, it must remain clearly bounded. It is not a diagnostic tool, not a treatment protocol, and not a substitute for professional care.

Used ethically, the model can support relapse prevention, lifestyle change, social reintegration, and recovery-oriented practice. It can help clients and professionals map non-clinical domains that influence well-being and identify areas for coordinated support.

Evaluation and Research Design

Future research should test the model empirically through pilot studies, quasi-experimental designs, randomized controlled trials where feasible, longitudinal follow-up, and mixed-method evaluation. Because the model is multidimensional, evaluation should include both general mental health outcomes and domain-specific indicators.

General outcomes may include symptoms of depression and anxiety, perceived stress, life satisfaction, flourishing, psychological well-being, meaning in life, emotional regulation, and help-seeking behavior. Domain-specific outcomes may include sleep quality, physical activity, cognitive flexibility, emotional literacy, loneliness, work engagement, burnout, financial stress, and digital habits.

Qualitative evaluation is also essential. Well-being education is not only a matter of score change. It also involves narrative identity, perceived agency, meaning, relationships, and lived experience. Interviews, reflective journals, focus groups, arts-based evaluation, and participant narratives can help capture dimensions that standardized measures may miss.

Implementation research should examine feasibility, acceptability, fidelity, cultural adaptation, facilitator training, institutional support, and cost-effectiveness. The model should be tested across schools, universities, workplaces, community programs, and clinical-adjacent settings.

Table 3: Suggested evaluation indicators and instruments.

Outcome area	Potential measure	Purpose	Notes
Depression	PHQ-9	Symptom screening	Not diagnostic without clinical assessment
Anxiety	GAD-7	Symptom screening	Useful for pre/post comparison
Well-being	WHO-5; PERMA-Profiler	Positive mental health	Can complement symptom measures
Stress	Perceived Stress Scale	Stress appraisal	Relevant to behavioral change
Burnout/work	MBI; UWES	Occupational functioning	Applicable in workplace studies
Meaning	Meaning in Life Questionnaire	Purpose and coherence	Relevant to transcendence domain
Social connection	UCLA Loneliness Scale; Social Connectedness Scale	Relational well-being	Useful for community programs
Sleep	Pittsburgh Sleep Quality Index	Body dimension	Can be paired with habit logs
Digital habits	Digital well-being scales; screen-time logs	Technology dimension	Requires careful interpretation
Financial stress	Financial strain or financial well-being scales	Financial balance	Context-sensitive

Ethical Considerations

A preventive well-being model must be ethically careful. The first risk is individual blame. People's suffering is shaped by biology, trauma, poverty, inequality, discrimination, family history, work conditions, social isolation, and access to care. Well-being education must not imply that people are responsible for all their suffering or that they can overcome any difficulty through attitude alone.

The second risk is happiness coercion. Contemporary societies sometimes transform well-being into another performance demand. People may feel obliged to appear positive, resilient, productive, and balanced even when they are suffering. Integral Well-Being Education must not become a culture of compulsory happiness. Its purpose is care, not pressure; dignity, not performance.

The third risk is clinical overreach. Facilitators of well-being education must know the limits of their role. They should be trained to identify warning signs, refer to professionals, protect confidentiality, and avoid giving clinical advice beyond their competence.

The fourth risk is cultural imposition. Concepts such as meaning, body, family, money, work, and technology vary across cultures and socioeconomic contexts. The model must be adapted respectfully. What counts as balance in one context may not be realistic in another.

The fifth risk is commercialization without evidence. Well-being has become a market. Ethical implementation requires transparent claims, evaluation, professional boundaries, and avoidance of exaggerated promises. The model should be presented as a preventive educational framework requiring validation, not as a guaranteed cure.

Limitations

This article presents a conceptual framework and does not report empirical findings. The model therefore requires validation before claims of effectiveness can be made. Its proposed mechanisms are plausible and evidence-informed, but they remain hypotheses for future research.

A second limitation is breadth. The eight dimensions offer comprehensiveness, but they also create implementation complexity. Programs must avoid superficiality. Depth, sequencing, facilitator training, and contextual adaptation are necessary.

A third limitation concerns measurement. Multidimensional well-being is difficult to capture with a single indicator. Evaluation should combine symptom measures, positive mental health measures, behavioral indicators, and qualitative data.
A fourth limitation concerns equity. Well-being education may be more easily accessed by individuals or institutions with resources. Public and community strategies are necessary to prevent the model from benefiting only privileged groups.

Finally, the model must be tested across cultures. Its domains are broad enough to be widely relevant, but their meanings, priorities, and pedagogical forms will differ by context.

Future Research Directions

- Develop and pilot a standardized Integral Well-Being Education curriculum for schools, universities, workplaces, and community settings.
- Test whether the model improves mental health literacy, emotional regulation, self-awareness, social connectedness, and help-seeking behavior.
- Evaluate whether the model reduces perceived stress, anxiety symptoms, depressive symptoms, loneliness, financial stress, burnout, and problematic digital habits.
- Examine whether arts-based learning increases engagement, emotional processing, and retention of well-being competencies.
- Compare the eight-dimensional model with narrower interventions to assess whether integrative design produces broader preventive effects.
- Study implementation fidelity, facilitator training, institutional support, cultural adaptation, and cost-effectiveness.
- Create a validated assessment instrument aligned with the eight domains, while avoiding reduction of well-being to a single score.

Conclusion

The mental health crisis cannot be addressed only after people collapse. It requires treatment, but also prevention. It requires services, but also education. It requires specialists, but also families, schools, workplaces, communities, and cultures that know how to care.

Integral Well-Being Education offers an eight-dimensional preventive framework for mental health promotion, behavioral health, and human flourishing. By integrating body, thought, emotions, transcendence and meaning, social relationships, professional life, financial balance, and technology, the model responds to the complexity of human life in contemporary societies.

Its central message is that well-being can be educated. People can learn to listen to their bodies, regulate their thoughts, understand their emotions, cultivate meaning, build healthier relationships, work with purpose, manage money consciously, and use technology with balance. These competencies do not eliminate suffering, but they can strengthen resilience, agency, and dignity.

The model is not a substitute for clinical care. It is a preventive educational architecture that can complement mental health systems and support a broader public health culture. In a world marked by acceleration, loneliness, uncertainty, financial stress, occupational pressure, and digital overload, mental health promotion must become an education for living.

The challenge ahead is empirical, institutional, and ethical: to validate the model, adapt it across cultures, implement it responsibly, and ensure that education for well-being does not become another privilege, but a shared human right and a public good.

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