

## **Dynamics of Wellbeing Co-Creation: A Psychological Ownership Perspective**

Tom Chen<sup>1,2,3</sup>, Sarah Dodds<sup>4</sup>, Jörg Finsterwalder<sup>5</sup>, Lars Witell<sup>6,7\*</sup>, Lilliemay Cheung<sup>8</sup>, Mareike Falter<sup>9</sup>, Tony Garry<sup>10</sup>, Hannah Snyder<sup>11</sup>, and Janet R. McColl-Kennedy<sup>8</sup>

<sup>1</sup> Canberra Business School, University of Canberra, Australia

<sup>2</sup> Research School of Population Health, and Research School of Management, Australian National University, Australia

<sup>3</sup> Newcastle Business School, University of Newcastle, Australia

<sup>4</sup> School of Communication, Journalism & Marketing, Massey University, New Zealand

<sup>5</sup> UC Business School, University of Canterbury, New Zealand

<sup>6</sup> Department of Management and Engineering, Linköping University, Sweden

<sup>7</sup> Service Research Centre (CTF), Karlstad University, Sweden

<sup>8</sup> UQ Business School, The University of Queensland, Australia

<sup>9</sup> Department of Service Management and Service Markets, University of Hohenheim, Germany

<sup>10</sup> Department of Marketing, University of Otago, New Zealand

<sup>11</sup> Norwegian Business School, Norway

\* Corresponding author

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## **Dynamics of Wellbeing Co-Creation: A Psychological Ownership Perspective**

### **ABSTRACT**

**Purpose**—People are responsible for their wellbeing, yet whether they take ownership of their own or even others' wellbeing might vary from actor to actor. Such psychological ownership (PO) influences the dynamics of how wellbeing is co-created, particularly amongst actors, and ultimately determines actors' subjective wellbeing. The paper's research objective pertains to explicating the concept of the co-creation of wellbeing and conceptualizing the dynamics inherent to the co-creation of wellbeing with consideration of the influences of all involved actors from a PO perspective.

**Design/methodology/approach**—To provide a new conceptualization and framework for the dynamics of wellbeing co-creation, this research synthesizes wellbeing, PO, and value co-creation literature. Four healthcare cases serve to illustrate the effects of engaged actors' psychological ownership on the co-creation of wellbeing.

**Findings**—The derived conceptual framework of dynamic co-creation of wellbeing suggests four main propositions: (1) the focal actor's wellbeing state is the intangible target of the focal actor's and other engaged actors' PO, transformed throughout the process of wellbeing co-creation, (2) PO over the focal actor's wellbeing state is subject to the three interrelated routes of exercising control, investing in the target, and intimately knowing the target, which determine the instigation of wellbeing co-creation, (3) the level of PO can vary over the focal actor's wellbeing state, influence and be influenced by the extent of wellbeing co-creation, (4) the co-creation of wellbeing, evoked by PO, is founded on resource integration, which influences the resources–challenges equilibrium of focal actor and of all other engaged actors, affecting individual subjective wellbeing.

**Originality/value**—This article provides a novel conceptual framework that can shed new light on the co-creation of wellbeing in service research. Through the introduction of psychological ownership the transformation of lives and wellbeing can be better understood.

**Keywords:** Psychological ownership, dynamics, wellbeing co-creation, subjective wellbeing, resources–challenges equilibrium, transformative service research, healthcare

**Paper type:** Conceptual paper

## INTRODUCTION

*I was outsourcing my health to somebody else. I was coming along saying, 'Here is my money. You fix me'” (Joe Cross cited in Siewierski, 2014).*

Human actors can contribute in various ways to improve their wellbeing (McColl-Kennedy *et al.*, 2012), and ideally should adopt an active stance (Caru and Cova, 2015; Prahalad and Ramaswamy, 2004) to “take ownership of [their] health” (Saint Thomas, 2016). However, while individual actors’ efforts are required to improve their own wellbeing (Sweeney *et al.*, 2015; McColl-Kennedy *et al.*, 2017b), such active participation cannot necessarily guarantee a positive outcome (Echeverri and Skålén, 2011; Watters *et al.*, 2001, Zycinska *et al.*, 2014). Their subjective evaluation of wellbeing (i.e. subjective wellbeing, SWB) may differ depending on their resource conditions and challenges (Dodge *et al.*, 2012). Sustaining a balanced wellbeing (Dodge *et al.*, 2012) of a focal actor (e.g., individual, healthcare customer, patient) often demands resource integration by other engaged actors (Kleinaltenkamp *et al.*, 2017) beyond the focal actor, such as professional service provider(s) (e.g., gym trainer, healthcare practitioner, physician, specialist) and affected others (e.g., gym member, family, friend). We argue that all these actors are interacting in a joint wellbeing co-creation sphere and account for their own wellbeing and that of others. In other words, subjective wellbeing as an outcome is dependent on a co-creation process which can involve multiple actors. To date, empirical studies cite a wide range of a focal actor’s co-creative roles and behaviors (e.g., McColl-Kennedy *et al.*, 2012, 2015), though the precise routes by which wellbeing is co-created among actors over time and its dynamics remain unclear. To address this gap, the current study draws on psychological ownership (PO) theory (Jussila *et al.*, 2015; Pierce *et al.*, 2003) as a lens, as it specifies routes that can inform an understanding of the dynamics of wellbeing co-creation. Accordingly, the two research objectives are (1) explicating the co-creation of wellbeing and (2) conceptualizing the dynamics of wellbeing

co-creation with consideration of the influences of other engaged actor(s) from a PO perspective. The resulting, wide-ranging implications hold promise for transforming actors' lives (Anderson and Ostrom, 2015), by detailing the psychological ownership of all engaged actors over a focal actor's wellbeing.

In so doing, the current study contributes to service research in five main ways. First, it recognizes the importance of wellbeing in service settings (McColl-Kennedy *et al.*, 2017a,b), lately spurred by the introduction and advancement of the research domain of Transformative Service Research (Anderson *et al.*, 2013; Dodds *et al.*, 2014, 2018; Finsterwalder *et al.*, 2017; Gallan *et al.*, 2019; Hepi *et al.*, 2017; Ostrom *et al.*, 2015), and expands on the concept of the co-creation of wellbeing. Second, it introduces PO to service research. Third, this article conceptualizes the dynamics of the co-creation of wellbeing from a PO perspective (Jussila *et al.*, 2015) and establishes a novel conceptual framework. We apply a conceptual research design which includes a blend of approaches outlined by Jaakkola (2020). We utilize theory synthesis, that is, integrate across multiple theoretical lenses, but also strongly focus on theory adaptation, the latter aiming at “[c]hanging the scope or perspective of an existing theory by informing it with other theories or perspectives” (Jaakkola, 2020). To achieve this, we problematize “an existing theory or concept [co-creation] and resolving identified dilemmas [understanding wellbeing] by introducing a new theoretical lens [psychological ownership]” (Jaakkola, 2020). Fourth, it provides propositions for viewing wellbeing through a co-creation and PO lens, illustrated with four cases from healthcare. Fifth, this article provides a research agenda and implications for service scholars, policymakers, and (healthcare) practitioners.

## THEORETICAL FRAMEWORK

### *Psychological Ownership (PO)*

A sense of possession (psychological ownership) is not always aligned with legal rights of ownership (Pierce *et al.*, 2003). The behavioral implications of PO have long been recognized in disciplines such as anthropology, psychology, social psychology, geography, history, and philosophy (Ye and Gawronski, 2016); it also has emerged as a focus in management research (Gineikiene *et al.*, 2017) that seeks individual-level predictors and consequences of PO, such as organizational commitment (Van Dyne and Pierce, 2004) or employee job satisfaction (Avey *et al.*, 2009). Growing interest has also arisen in marketing (Harmeling *et al.*, 2017; Hulland *et al.*, 2015; Sun *et al.*, 2016). Here, PO has potential implications for understanding consumer behavior, including positive attitudes toward target objects (Beggan, 1992; Feuchtl and Kamleitner, 2009; Sun *et al.*, 2016). Identified outcomes include customer satisfaction, relational intentions, competitive resistance (Asatryan and Oh, 2008; Fuchs *et al.*, 2010), product consideration (Kamleitner and Feuchtl, 2015), and product acquisition (Kamleitner, 2011). Notwithstanding these insights—and despite the presence of some notable exceptions (Asatryan and Oh, 2008) and similar construct conceptualizations (Harwood and Garry, 2010), such as sense of ownership (Ng *et al.*, 2019)—PO has yet to be leveraged in service research (Jussila *et al.*, 2015), particularly to better comprehend co-creation in a wellbeing context.

Jussila *et al.* (2015, p. 121) define PO as “a personal sense of possession an individual holds for a material or immaterial target (i.e., ‘This is MINE!’).” Feelings of PO are not prone to “switching on and off” (Jussila *et al.*, 2015). Rather, they emerge over time through three interrelated *routes* to psychological ownership (Dirks *et al.*, 1996): (1) self-initiated responsibility and exercise of control, (2) investing the self in an ownership target and its evolution, and (3) intimate knowledge of the ownership target. The drive to exercise PO

stems from four basic human needs that act as motivators: (1) efficacy and effectance, (2) self-identity, (3) having a place, and (4) stimulation and arousal (Pierce *et al.*, 2003). These so-called *roots* are motivational conditions that may be satisfied through the evocation of PO (Jussila *et al.*, 2015). Previous research suggests that PO is pivotal in facilitating positive behavioral outcomes (Hulland *et al.*, 2015; Vandewalle *et al.*, 1995). However, a sense of ownership can lead to territorial behaviors (Brown *et al.*, 2014) that threaten to decrease wellbeing. Considering that PO can lead to both promotion and prevention outcomes (Higgins, 1998), it suggests a conceptual alignment with work on value co-creation and value co-destruction (Echeverri and Skålén, 2011; Plé and Chumpitaz Cáceres, 2010) as well as wellbeing improvement (positive wellbeing) and wellbeing deterioration (negative wellbeing) (Zycinska *et al.*, 2014). This reasoning is the starting point for this paper's investigation and in line with work claiming that feelings of PO stimulate behaviors that contribute to the target of ownership's wellbeing (Van Dyne and Pierce, 2004). Co-creation of wellbeing can achieve this but this requires the unravelling of the dynamics involved in processes when actors instigate exercising PO.

### ***Wellbeing***

Wellbeing is a growing research field (La Placa *et al.*, 2013), gaining momentum in service research due to the potential impact of policy and service provision on individual and societal wellbeing (Anderson *et al.*, 2013). In turn, “improving well-being through transformative service” (Ostrom *et al.*, 2015, p. 127) is a research priority, reflecting the transformative potential of service and the notion that wellbeing is critical to service policy and practice (Ostrom *et al.*, 2015; Steptoe *et al.*, 2015). In Transformative Service Research (TSR) literature, wellbeing outcomes reflect the emphasis on both individuals and the collective, “which include groups such as families, social networks, neighborhoods, communities, cities, and nations” (Anderson *et al.*, 2013, p. 1206). Co-creation of wellbeing



in this sense “requires the involvement of the focal actor (...) and their service or activity system, as well as (...) of other actors” (Finsterwalder *et al.*, 2017, p. 766). In other words, the transformation of lives of focal actors is enabled by being situated in dynamic social systems, which include other actors, and by resource integration (Blocker and Barrios, 2015; Edvardsson *et al.*, 2011).

In service research in general, wellbeing is also considered a key outcome of value co-creation (Blocker and Barrios, 2015; Diener and Chan, 2011; Pera and Viglia, 2015). These views imply that wellbeing can be co-created (Hepi *et al.*, 2017). However, despite the importance of wellbeing in service research the co-creation process of wellbeing and its dynamics remain understudied. In this paper, we address this gap.

### ***Common View of Wellbeing***

A common measure of wellbeing, also reflected in TSR (Anderson *et al.*, 2013), is subjective wellbeing (SWB) which evaluates happiness and other aspects of quality of life (Frow *et al.*, 2016; Steptoe *et al.*, 2015). SWB is defined as “people’s evaluations of their lives—the degree to which their thoughtful appraisals and affective reactions indicate that their lives are desirable and proceeding well” (Diener *et al.*, 2015, p. 234). Likewise the psychological wellbeing concepts, hedonic and eudaimonic wellbeing, are often used in literature, such as in TSR (Anderson *et al.*, 2013), to measure an actor’s evaluation of their wellbeing. The hedonic perspective of wellbeing focuses on subjective happiness, pleasure and the absence of pain (Kahnemann *et al.*, 1999; Ryan and Deci, 2001), whereas the eudaimonic perspective of wellbeing focuses on realizing human potential, living a meaningful life and having good relationships with others (Huta and Ryan, 2006). These concepts of wellbeing are useful for measuring an individual’s perception of their wellbeing. However, they only capture an actor’s wellbeing outcome but remain silent in regard to explicating the dynamic and co-creative nature of wellbeing (Dodge *et al.*, 2012) and how a

particular *wellbeing state* has come about. As a reference table 1 summarizes the key wellbeing conceptualizations reviewed, utilized and introduced in this paper.

---TABLE 1 HERE---

### ***A Resources vs Challenges Based View of Wellbeing***

Wellbeing can fluctuate, i.e. it can deteriorate or improve, and depends on each actor's context (McNaught, 2011; La Placa *et al.*, 2013). To reflect this nature of wellbeing Dodge *et al.* (2012) suggest a set point at which wellbeing exists, which requires an equilibrium between resources and challenges, even as wellbeing states change (subject to the context). Dodge *et al.*'s (2012, p. 230) conceptualization of wellbeing cites “the balance point between an individual's resource pool and the challenges faced” as the locus of wellbeing. An actor's wellbeing is inherently multidimensional and affected by various aspects in life—health, employment, material resources, relationships, and so forth (Decancq and Lugo, 2012; Kahneman and Krueger, 2006)—that change over time.

To achieve what can be termed Dodge *et al.*'s (2012) resources–challenges equilibrium (RCE), which depicts a wellbeing *state*, actors have to reduce cognitive, psychological, physical, and social challenges and integrate cognitive, psychological, physical, and social resources (Dodge *et al.*, 2012; Smith, 2013). Social resources comprise other engaged actors and their resource integration efforts (Kleinaltenkamp *et al.*, 2012; 2017), such as family members and healthcare practitioners, who can assist with co-creating a focal actor's wellbeing (McColl-Kennedy *et al.*, 2017b). Therefore, all engaged actors must be considered in the co-creation of wellbeing (Dodge *et al.*, 2012; Finsterwalder and Kuppelwieser, 2020; La Placa *et al.*, 2013).

While an imbalance of resources and challenges of the focal actor may stimulate resource integration activities, the effectiveness of balancing and the resulting wellbeing depends on the resource integration abilities of the focal actor and other engaged actors.

### ***Definition of Wellbeing Co-creation***

Wellbeing co-creation is attained through the integration of actors' resources. It will assist with achieving a balance point or equilibrium (RCE) of the focal actor's challenges and resources (Dodge *et al.*, 2012) and has its outcome in a change of a focal actor's perceived subjective wellbeing (SWB) (Busser and Shulga, 2018). This line of argument is congruent with Cummins' (1998) work on the strength of a challenge and how it affects the level of SWB. It also aligns with conceptualizations of resource integration and value in connection with wellbeing (Black and Gallan, 2015; Blocker and Barrios, 2015; Diener and Chan, 2011; Hepi *et al.*, 2017) in the service literature.

Extant service research suggests that value co-creation can lead to changes in wellbeing of a social system and the actors in the system (Edvardson *et al.*, 2011; Vargo and Lusch, 2014) due to exchanges among actors (Chandler and Vargo, 2011; Frow *et al.*, 2016). While value co-creation can lead to positive wellbeing (Hepi *et al.*, 2017; Watters *et al.*, 2001), value co-destruction (Echeverri and Skålén, 2011; Plé and Chumpitaz Cáceres, 2010) can lead to negative wellbeing (Finsterwalder and Kuppelwieser, 2020; Zycinska *et al.*, 2014). The co-creation of wellbeing can be constrained by a lack of access to resources, a lack of connections to key actors in the service or activity system, or contested institutional access due to tensions or conflicts with normative rules and values (Frow *et al.*, 2016; Hepi *et al.*, 2017).

On the basis of this reasoning, the current study employs the term *co-creation of wellbeing* to define a transformative *process* whereby a focal actor's subjective wellbeing is the *outcome* of balancing challenges and resources to achieve an equilibrium (*state*), and this

depends on the focal actor's and other engaged actors' psychological ownership over the focal actor's wellbeing and subsequent resource integration. This conceptualization accounts for (1) the embeddedness of all engaged actors in a social system, (2) the processual nature of wellbeing co-creation, (3) the ratio of resources to challenges of all engaged actors, (4) the extent of PO as individually perceived by all engaged actors, (5) the extent of resource integration, and (6) the focal actor's but also other engaged actors' subjective wellbeing as the consequence of wellbeing transformation. Notably, this work includes at least two types of engaged actors: the *focal actor* who is at the center of health and wellbeing challenges and efforts as well as *other engaged actors*, who can be instrumental in transforming the focal actor's wellbeing (Kleinaltenkamp *et al.*, 2017). For the key definitions employed in this paper refer to Appendix 1.

### **DYNAMICS OF CO-CREATION OF WELLBEING**

Service research suggests that value co-creation entails a dynamic, iterative process (Chen *et al.*, 2017). Accordingly, and drawing on the definition provided above, the co-creation of wellbeing is inherently dynamic, involving a process undertaken by the focal and other engaged actors, through their integration of resources (Kleinaltenkamp *et al.*, 2012; McColl-Kennedy *et al.*, 2017a). The dynamics of wellbeing co-creation are stimulated by the interplay of roles, efforts, and desire for betterment among engaged actors (Chen *et al.*, 2017) and can be explained through the concept of Psychological Ownership (PO). PO over a focal actor's wellbeing, i.e. their *state of wellbeing* as defined by Dodge *et al.* (2012) can drive engaged actors' behavior which in turn influences the contribution made to the co-creation of wellbeing process. In essence, PO of actors determines their motivation to engage in wellbeing co-creation which can improve or deteriorate the resource conditions of the focal actor and amplify or mitigate the associated challenges. Thus, the co-creation of wellbeing is founded on resource integration by all involved actors which influences the resources-challenges equilibrium (RCE)

of focal actor and of all other engaged actors and, in turn, affects the perception of SWB by the focal actor and all other engaged actors. In other words, the concept of the wellbeing state, i.e. achieving a resources–challenges equilibrium (RCE, *state*) is the bridging concept that connects individual and hence subjective perceptions of wellbeing (SWB, *outcome*), with the concept of co-creation of wellbeing (CCW, *process*) where engaged actors jointly create a new resources–challenges equilibrium (RCE) or wellbeing state with a focal actor. The conceptual bridge is created from a resource perspective, i.e. from the viewpoint of value co-creation literature (e.g., Chandler and Vargo, 2011) via the notion of resource integration, and from the perspective of wellbeing literature (Dodge *et al.*, 2012) via the resources–challenges equilibrium concept.

The following four propositions are suggested to explain the conceptualizations that underpin the dynamics of co-creation of wellbeing that are at play while aiming to transform a focal actor’s wellbeing state and ultimately their perception of subjective wellbeing.

#### *Engaged Actors’ Psychological Ownership*

Psychological ownership can apply to tangible (e.g., physical good, physical space) or intangible (e.g., ideas, values) targets, “sensed” as being the person’s own. Despite some debate about what can qualify as a target of PO (Hulland *et al.*, 2015; Pierce and Jussila, 2011), consensus exists that people are motivated to engage in behaviors that “nurture, advance and protect the target of ownership” (Jussila *et al.*, 2015, p. 130). Given that PO can have an intangible target, it is reasonable to postulate that wellbeing can be an intangible target (Hepi *et al.*, 2017; Van Dyne and Pierce, 2004) of the focal actor and engaged other actors (e.g., “my wellbeing”, “my husband’s wellbeing”, “my patient’s wellbeing”). This explains why a focal actor and other engaged actors, such as sports club members, family members, doctors etc. may feel a personal sense of ownership over a focal actor’s wellbeing, specifically, the focal actor’s wellbeing state (resources-challenges equilibrium, RCE).

Formally, we propose:

**Proposition 1:** The focal actor's wellbeing state (RCE) is the intangible target of the focal actor's and other engaged actors' psychological ownership, transformed throughout the process of wellbeing co-creation.

### *Three Interrelated Routes to Psychological Ownership*

Three main *routes* all give rise to PO. Therefore pursuing these routes to PO, including a sense of control, intimately knowing a target, and investing in the target, is also required (Pierce *et al.*, 2001). Greater control over, familiarity with, and investment of self in support of the focal actor's health thus should stimulate feelings of PO over the focal actor's wellbeing state. Specifically, when focal actors have a heightened sense of control due to perceptions of the severity of a current health condition, the affordability of treatment, and/or empowerment drawn from support by peer groups or families, they also experience PO: "He has too much going on besides being sick as he is out of work. I want to help as he is a close friend". On the route created by intimate knowledge of the target, focal actors might document their own wellbeing, compare it with publicly listed symptoms (e.g., on websites), and study treatment options. Such actions also imply investing in the target, in the form of devoting time to rehabilitation efforts, actively interacting with other patients and healthcare practitioners, or researching healthy living options for after the treatment is complete. Likewise, engaged other actors might develop PO over the focal actor's wellbeing due to intimate knowing of the focal actor, for example, a wife's intimate knowing of her husband, or a doctor's intimate knowing of a focal actor's health history. This intimate knowing can influence a sense of control and investment in the focal actor's wellbeing. Equally, the three routes to PO may not guarantee improved wellbeing, for example, if a focal actor is overwhelmed with anxiety, their ability to exercise control is diminished. Or if a family member does not agree with the focal actor's decision to become a vegan to improve their

wellbeing, their resource integration activities to change the focal actor's wellbeing state may decrease.

Formally, we propose:

**Proposition 2:** Psychological ownership over the focal actor's wellbeing state (RCE) is subject to the three interrelated routes of exercising control, investing in the target, and intimately knowing the target, which determine the instigation of wellbeing co-creation.

#### *Levels of Psychological Ownership*

PO tends to emerge over time (Dirks *et al.*, 1996) and can be subject to varying levels at different points in time by both focal and engaged actors (Jussila *et al.*, 2015). At certain points in a person's health and wellbeing journey, PO over their wellbeing can vary, increasing or diminishing over time. For example, focal actors who partake in extra-role behavior and commit to and take responsibility for their health likely exhibit engagement in their own wellbeing and healthcare (McColl-Kennedy *et al.* 2012; Sweeney *et al.*, 2015). Interactions with other engaged actors (e.g., dietician) could increase both the focal actor's and the other engaged actors' PO over the focal actor's wellbeing state and thereby prompt even more engagement in health-related activities (e.g., changing their diet). Levels of PO (i.e. how strong the feelings of ownership are), in turn, would influence the contribution made by the focal actor and engaged other actors to the co-creation of wellbeing (Anderson *et al.*, 2013; Hair *et al.*, 2016). Therefore, SWB perceived by the focal actor is influenced by the co-creation of wellbeing (Busser and Shulga, 2018) as it changes the resources–challenges balance.

Formally, we propose:

**Proposition 3:** The level of psychological ownership can vary over the focal actor's wellbeing state (RCE), influence and be influenced by the extent of wellbeing co-creation.

*Psychological Ownership and Resource Integration*

The level of PO is associated with the evaluation of the focal actor's and engaged other actor's existing resource conditions and challenges. In the proposed conceptual framework, cognitive, psychological, physical, and social *challenges*, relative to the cognitive, psychological, physical, and social *resources* available, can influence the resources-challenges equilibrium (RCE) and subsequent assessments of SWB by the focal actor, and by all other engaged actors. For example, a low level of available resources to the focal actor, combined with severe challenges, might require greater integration of resources by other engaged actors to better the focal actor's health. Moreover, more challenges for a focal actor might increase their willingness to integrate others' resources. When focal actors enjoy the support of other engaged actors, they might also be better able to integrate resources and master challenges, by bundling their own and others' resources. Actors' resource integration, therefore, can improve the focal actor's resource conditions and alleviate the challenges.

PO can influence the focal actor's resource conditions positively or negatively. Resource replenishment or depletion over time can change the level of PO of these engaged actors and lead to the contraction or expansion of wellbeing co-creation. Moreover, a focal actor's PO can result from a greater understanding of their health and the need to take ownership of it, because this understanding implies an investment of some cognitive resources to comprehend and contemplate the status quo of their own wellbeing. Such comprehension exercise might benefit from the integration of other resources, such as using a Fitbit device to record health data, gather feedback on training progress, and determine sleep



patterns. However, the development of PO does not always change the wellbeing state for the better and can deter resource integration of engaged actors. For example, tensions may arise among actors due to territoriality issues, such as when the focal actor is not equipped with sufficient resources to achieve wellbeing, thus other engaged actors might intervene and seek control over the focal actor's wellbeing. Such tensions may lead to the depletion or conservation of resources and the withdrawal of one or more engaged actors and ultimately to negative subjective wellbeing. Moreover, other engaged actors' PO over the focal actor's co-created wellbeing depends on the challenges they face and the resources they can integrate, this in turn can influence both the focal actor's and engaged actors' RCE, and ultimately the SWB of all involved actors. That is, resources can be the focal actor's own or be drawn from other engaged actors.

Formally, we propose:

**Proposition 4:** The co-creation of wellbeing, evoked by psychological ownership, is founded on resource integration which influences the resources-challenges equilibrium (RCE) of the focal actor and of all other engaged actors, affecting individual subjective wellbeing (SWB).

### *Conceptual Model*

Figure 1 illustrates the novel framework that depicts the dynamics in the co-creation of wellbeing. The framework consists of an *actor sphere*, i.e. the locus of subjective wellbeing (SWB) as an *outcome* as well as the *state* of existing challenges vs resources, depicted as the balance shaped resources-challenges equilibrium (RCE) in the illustration. Although only two actors are depicted, each with their unique sets of challenges and resources, and derived from these stem their individual perceptions of wellbeing (SWB), wellbeing co-creation can involve more than these two actors. However, for illustrative purposes we showcase the underlying mechanisms utilizing only two actors. One of the actors is the focal actor at the

center of wellbeing and healthcare related efforts. The other actor could be any actor or a multitude of actors, representing other engaged actors who take PO over the focal actor's wellbeing state. It is important to note that although the focal actor's wellbeing state (RCE), is the intangible target of PO, all other engaged actors' wellbeing states (RCEs) also need to be considered in the co-creation of wellbeing.

The wellbeing co-creation *process* occurs in the joint sphere depicted in the middle. Depending on each actor's level of PO, exemplarily indicated by three different PO levels (PO<sub>1</sub>, PO<sub>2</sub>, PO<sub>3</sub>) for each actor in the illustration, co-creation activities will ensue. For example, the focal actor might have low PO over their wellbeing (PO<sub>1</sub>) and challenges outweigh the resources available leading to the perception of negative subjective wellbeing (SWB). An engaged actor might feel strongly about the focal actor's wellbeing state and has a high level of PO (PO<sub>3</sub>) over their wellbeing, for example, by intimately knowing the target, i.e. the focal actor and their decline in wellbeing. Compared to their own challenges, the engaged actor might have excess resources available they can use to co-create wellbeing with the focal actor. In turn, such co-creative process by integrating engaged actor's resources might motivate the focal actor to increase their PO<sub>1</sub> to PO<sub>2</sub>, take more ownership of their wellbeing and engage more in co-creation. This might be spurred by the increase of resources integrated by the engaged actor, such as social or financial support. Such interplay of PO and its routes and levels, the different resource pools and challenges of multiple actors involved make co-creation of wellbeing a truly dynamic process.

--- Figure 1 about here ---

## **APPLICATION OF THE FRAMEWORK TO HEALTHCARE**

Compared to only focusing on individual improvements of everyday wellbeing, the healthcare context was chosen because it depicts the most complex application of the conceptual development in a service system; involving multiple actors and having individual, family, community, society wellbeing as a central concern (Anderson *et al.*, 2013). Four real cases, derived from primary qualitative data collected from practitioners' perspectives (one case) and healthcare customers' perspectives (three cases), are utilized to substantiate the conceptualizations presented in this paper. Each case is written from varying actors' perspectives to demonstrate a) the role PO plays in the co-creation of wellbeing, and b) the dynamic nature of PO in the co-creation of wellbeing. Case 1 is from a healthcare practitioner's perspective (as an engaged other actor), case 2 is from both a family member (engaged other actor) and focal actor's perspective, and cases 3 and 4 are from healthcare customers' (as focal actors) perspectives. Extracts from the interview transcripts are used for illustrative purposes.

### ***Case 1: Psychological Ownership from a Healthcare Practitioner's Perspective***

#### Case Background

Case 1 is from a healthcare practitioner's perspective (Nurse Jill), who works for a healthcare service that focuses on the wellbeing of young children, particularly newborns, and provides support for their primary caregivers. The case is centered on a newborn baby (focal actor), the mother as primary caregiver and nurse practitioner (engaged actors) and the services of the Salvation Army (other actors). The focal actor was born into a family with limited psychological, social and financial resources. The father is unwell and cannot work, and there is no extended family available for support. Nurse Jill's primary concern is the wellbeing of the baby and supporting the family as is evident in this comment: “[T]hey [family] just had nothing...we give them all the support we can.”

#### Role PO Plays in the Co-creation of Wellbeing

The co-creation of wellbeing in this case arises primarily from Nurse Jill's PO over the baby's wellbeing, with support from the Salvation Army. Nurse Jill assumes PO over both the baby's and mother's wellbeing by investing herself into the target (Proposition 1 and 2)– "*my client's wellbeing.*" As Nurse Jill asserts, "*it was a bigger support role than most mums would need*", therefore she gave them as much "*support*" (Proposition 2) as possible by organizing resources (Proposition 4), such as nappies and formula, from other services (e.g. Salvation Army) – "*I organized a Salvation Army pack for them*" –, and providing emotional and psychological support, through "*connection*" and "*reassurance.*"

### Dynamics of the Co-creation of Wellbeing

Initially Nurse Jill has PO over the baby's wellbeing through facilitating the co-creation of wellbeing for both the baby and mother by co-ordinating, leveraging and providing resources (physical, psychological and social) to help alleviate the challenges (Proposition 4). Once some of the challenges associated with the resource conditions of baby and mother were addressed, Nurse Jill's PO over the baby's (and mother's) wellbeing diminishes, until she no longer needed to visit (Proposition 3): "*[Y]ou do go through a lot with people, but then you need to move on.*" This varying level of PO over the focal actor's wellbeing arises largely because Nurse Jill provides resources (psychological, physical, and social) up until the point that she knows the wellbeing of the focal actor is improving and then her PO over their wellbeing reduces and the extent of wellbeing co-creation reduces (Proposition 3 and 4).

### ***Case 2: Psychological Ownership from both a Focal Actor's and Engaged Actor's***

#### ***Perspective***

#### Case Background

Case 2 is centered around Fred, 91 (as focal actor), and is viewed from both Fred's and his wife Dot's, 70, perspectives (both were interviewed together). The case includes their

perceptions of healthcare services/practitioners (doctor, speech therapist and respite care nurses), family, and friends (as engaged actors) involved and invested in Fred's health and wellbeing. Fred, after years of great health and managing his own wellbeing, is experiencing physical, psychological, cognitive and social challenges, due to congestive heart failure and subsequent deteriorating mental health. As Fred laments he has had to "*adjust to living life with this wretched health thing*" with Dot having to organize and manage resources (e.g. Doctor's appointments, social outings, respite care) to ensure the co-creation of Fred's wellbeing (Proposition 4).

#### Role PO Plays in the Co-creation of Wellbeing

Due to Fred's physical and psychological challenges he has lost some of his sense of intimate knowing and ability to exercise control (Proposition 2): "*I'm at a stage of transition...adjusting...to living a life of that type [with challenges].*" Therefore his PO over his wellbeing (intangible target) has diminished (Proposition 1). As Dot comments, "*it's been sort of happening gradually over the last three years*" and consequently she has assumed greater PO over Fred's wellbeing by investing more in his "*health management*" and personal wellbeing, owing to her intimate knowing of Fred (Proposition 1 and 2). Despite Fred's diminishing PO he is aware of Dot's contribution and the importance of good healthcare services to co-creating his wellbeing (Proposition 2), noting that "*the service we get at our doctor [is good] ... just as well, because we've needed it... nurses are coming...[to change] dressings [regularly].*" Dot ensures both her and Fred's wellbeing is maintained by engaging other actors to replenish their resources and reduce challenges, by organizing doctor's visits, visitors, social outings, and respite care as needed and points out that "*we had a speech therapist here the other day.*" She has also organized "*specialists*", "*respite care...to give me a break*", and "*family and friends*" to visit and help out (Proposition 4).

This signals that all those involved, invest their self in Fred's wellbeing (PO target) (Proposition 1 and 2) contributing to the co-creation of his wellbeing.

### Dynamics of the Co-creation of Wellbeing

PO and the co-creation of Fred's wellbeing fluctuates, with various actors having more or less PO at any given time, and hence contributing to co-creating his wellbeing (i.e. investing more or less resources) (Proposition 3). On a day-to-day basis, Dot has high PO and is a key engaged actor in the co-creation of Fred's wellbeing due to investing a lot of resources (Proposition 3 and 4). When Dot needs a break and Fred goes to respite care for a week, the nurses looking after Fred assume PO over Fred's wellbeing. Likewise, when Fred is at home and the nurses and speech therapist visit, they assume PO over Fred's wellbeing. Fred's PO over his own wellbeing is also constantly changing; when he is at home and feels coherent, he takes more PO, but when he is incapacitated, his PO diminishes, impacting on his ability to engage in the co-creation of his wellbeing (Proposition 3).

### ***Case 3: Psychological Ownership from a Healthcare Customer's (Focal Actor's)***

#### ***Perspective***

#### Case Background

Case 3 is from a healthcare customer's perspective. Margaret, 48, is in the process of co-creating her wellbeing to seek a long-term solution to a physical challenge (chronic shoulder and neck pain), that impacts on her social and psychological wellbeing, as she comments: *"I'm just in constant pain, stiff necks, sore arms.... I needed a long-term solution."* In this case, Margaret (focal actor) manages her doctor and chiropractor (as other engaged actors) to find a solution. Margaret discussed her options with her doctor, who recommends that she consult with an orthopaedic surgeon. However, Margaret has decided that surgery is not a good option at this stage and seeks out a chiropractor. Margaret explains: *"I was in pain and I needed to have something done, the doctor had suggested surgery, so I*

*said well no I'm not keen on that path... so I thought well I'll give it [chiropractor] a go and just see what happens".*

### Role PO Plays in the Co-creation of Wellbeing

After years of relying on “*lots of anti-inflammatory medication*” when the “*pain would be really bad*”, Margaret assumes PO over her wellbeing (Proposition 1), by investing herself in her own wellbeing and exercising control (Proposition 2). She explicitly explains: “*I am taking responsibility for my health, for my wellbeing by looking for an alternative.*” Margaret begins to co-create wellbeing by investing resources, such as financial resources, to pursue alternative healthcare (Proposition 4). Margaret decides that she is “*going to pay the money and see how it [chiropractor] goes.*” Her experience with the chiropractor is paramount to her maintaining high PO (Proposition 3). The consultative style of the chiropractor and shared decision-making enables Margaret to maintain a sense of control (Proposition 2) and engage in the process. The chiropractor assumes PO over Margaret’s wellbeing (Proposition 1) and “*was guided by what he said... he had a plan*”; thus the chiropractor facilitates the co-creation of wellbeing by working with her (Proposition 4), such that “*the chiropractor explained everything ... explained how the spine worked ... we discussed the treatment plan.*” Margaret is empowered by this experience, commenting that “*it does give you more power to actually understand what’s going on.*”

### Dynamics of the Co-creation of Wellbeing

Initially Margaret’s lower PO over her wellbeing increased and then remained high as she took more continuous responsibility, and invested in resources by going to a chiropractor (Proposition 3 and 4), as Margaret explains: “*I’ve gone from pain to being welcomed at the chiropractor to being explained what was going on and how it’s going on... [and now I’m] back in action doing things I haven’t been able to do before... it’s helped me mentally and physically.*” To begin with Margaret visited the chiropractor two to three times per week for a

period of six weeks; the frequency later decreased to once per week and then once per month, at which point she experienced long-term pain relief. It can be concluded that during this period the chiropractor initially had high PO, but as Margaret improved and reduced her visits the chiropractor's PO also decreased and subsequently his involvement in the co-creation of her wellbeing (Proposition 4).

#### ***Case 4: Psychological Ownership from a Healthcare Customer's (Focal Actor's)***

##### ***Perspective***

##### Case Background

Case 4 revolves around Jane, 51 (focal actor), and her healthcare experiences during treatment for lung cancer. The case includes Jane's perceptions of healthcare services/practitioner (oncologist, natural healthcare practitioner), cancer support services (Dove House) and family (as engaged actors) that were involved and invested in her health and wellbeing. After discussions with her oncologist and meetings with a natural health practitioner, Jane decides "*to do both*" chemotherapy and natural therapy. An integrated approach to her healthcare appeared paramount, and she feels "*fortunate*" to have the "*best of both worlds*".

##### Role PO Plays in the Co-creation of Wellbeing

Her oncologist explains that "*time is not on your side*" and takes immediate PO over Jane's wellbeing (Proposition 1), saying "*I don't want to keep you out of my sight for too long.*" Initially the oncologist exercises control (Proposition 2), but after dealing with the challenge of the initial "*shock*," Jane begins exercising more control and investing herself to enhance PO over her wellbeing (Proposition 2). Jane realizes she needs to "*put everything into [beating the cancer].*" Jane has resources (social, financial, and psychological) to cope with the challenge of cancer (Proposition 4), as she explains "*I was fortunate that I didn't have to hold down a fulltime job.... I had the luxury of being able to sleep when I needed to*



*but, yeah, it was a big undertaking but I had fantastic support from my family*". Critical to the co-creation of wellbeing are her relationships with the natural health practitioner who *"guided me through the holistic way... he's totally there for you"*, Dove House (cancer support centre) who became her *"absolute lifeline for about 6 to 8 months"*, and *"amazing"* family. All these engaged actors assume PO over Jane's wellbeing by investing themselves and resources (Proposition 2 and 4). Of great importance to Jane is the oncologist's and natural healthcare practitioner's preparedness to work together with her, to co-create wellbeing. As Jane states: *"I'm living proof that it [co-creation of wellbeing] works... I'm about 19 months now [since diagnosis] and I'm really, really well."*

#### Dynamics of the Co-creation of Wellbeing

When Jane is first diagnosed, PO over her wellbeing is low, and she dips into *"a very dark black hole"* and *"couldn't see the way out of it"* (Proposition 2). Once Jane realises she needs to take more control, she enlists her sister-in-law to help find a natural health practitioner, and *"read cancer books, [study] cancer, cancer, cancer, alternative stuff and nutrition"*, increasing PO over her wellbeing (Proposition 3). As Jane undergoes treatment, both chemotherapy and natural therapy, she maintains her high PO by continually seeking support and co-creating wellbeing with other actors, such as Dove House. Likewise, her oncologist, natural healthcare practitioner, people at Dove House, all continue to maintain PO, such that she always *"felt supported"* (Propositions 3 and 4). However, after her chemotherapy treatment ends and when Jane starts to recover, she reduces her visits to the natural health practitioner to *"once every three months"* because as she states, *"now that I'm doing so well"* she doesn't have to *"rely on him for support"*, indicating that his PO over her wellbeing naturally diminishes, and thus his involvement in co-creating wellbeing (Proposition 4). Parallels can be drawn regarding similar occurrences with her oncologist and with people at Dove House who provide support.

## DISCUSSION

Scholars have called for more research on how wellbeing is co-created (Ostrom *et al.*, 2015). By explaining the role PO embodies in the dynamics of wellbeing co-creation, this study extends existing work on wellbeing and the transformation of lives by providing several contributions to theory and practice.

### *Theoretical Contributions*

By building on the concept of Transformative Service Research (Anderson *et al.*, 2013; Ostrom *et al.*, 2015), this study further explores the concept of wellbeing. Recently, work at the intersection of wellbeing and service research has started to spike (Dodds *et al.*, 2014; 2018; Hepi *et al.*, 2017; McColl-Kennedy *et al.*, 2017a,b), and this paper adds to the body of knowledge by expanding on the concept of the co-creation of wellbeing (Finsterwalder and Kuppelwieser, 2020; Hepi *et al.*, 2017) via exploring the processual nature of wellbeing that leads to positive outcomes for focal and other engaged actors.

Further, this research develops a novel conceptual framework relating to the dynamics of wellbeing co-creation. Our framework introduces the resources–challenges equilibrium (RCE) view of wellbeing (Dodge *et al.*, 2012) to wellbeing and Transformative Service Research. Moreover, it also introduces psychological ownership to wellbeing research to explain the dynamics inherent to the co-creation of wellbeing. Foremost, it establishes four propositions regarding the dynamics of wellbeing co-creation. Real cases are used to demonstrate the role of PO as a theoretical construct to explain wellbeing co-creation, and the dynamics of the co-creation of wellbeing. The conceptualization of the dynamics of wellbeing co-creation are shown in the cases by illustrating the varying levels of PO, the constant fluctuation of resources and challenges, and positive and negative consequences, which have not previously been acknowledged. Drawing on the core concepts of PO and co-creation of wellbeing, the conceptual framework addresses key questions such as the role of

multiple actors in co-creating wellbeing, how wellbeing is shaped through the influence of varying levels of psychological ownership over a focal actor's wellbeing, and how collective resource integration influences the resources–challenges equilibrium (RCE).

A key contribution of this paper is the introduction of PO to wellbeing related service research. The conceptualization proposes, and illustrative cases show, that PO can explicate the effects of wellbeing co-creation in terms of both the practice level (McColl-Kennedy *et al.*, 2017b) and the individual actor level (McColl-Kennedy *et al.*, 2017a). At the practice level, PO can serve as an additional explanation for the shift from a traditional model of care toward self-managed care, shared decision-making (SDM) and person- and people-centered healthcare (PPCHC) (Lukersmith *et al.*, 2016) (see Appendix 2). At the individual actor level, this study distinguishes between SWB, RCE wellbeing and wellbeing co-creation: The first is an individual evaluation of personal wellbeing, the second is a state of wellbeing that involves balancing resources and challenges, whereas the latter reflects both the focal actor's and other engaged actors' PO and resource conditions and resulting co-creative activities, which then influence individual SWB. The findings demonstrate the explanatory power of PO in service research, suggesting the potential benefits of studying PO further, as outlined subsequently in the research agenda.

### ***Practical Implications***

The four illustrative cases depict the impact of PO on wellbeing co-creation, thereby revealing why it is important to attend to PO when co-creating wellbeing. In a healthcare context, healthcare practitioners (doctors, nurses, etc.) could be made aware of how their level of PO and their role in co-creating wellbeing is critical to both a person's wellbeing state (RCE) and ultimately their subjective wellbeing (SWB). Equally, healthcare practitioners need to be aware of how important the focal actor's (patient, healthcare customer) levels of PO and role in co-creating wellbeing is and encourage them to be

involved in decision-making and to take some responsibility for their wellbeing. This will become even more important as healthcare moves towards a people-centred approach to healthcare (PPCHC) (Lukersmith *et al.*, 2016).

Policymakers in a healthcare context need to recognize the dynamic nature and interrelationships of wellbeing co-creation and PO. The focal actor might require support not only from healthcare practitioners but also from the immediate and personal service system. Public policy should be designed to strengthen the position of and recognition for other engaged actors, such as family and friends, by enabling the leveraging of their resources and to ensure support can be provided. For example, family members could be granted taking leave from their job to be able to integrate their resources with a focal actor (family member). However, depending on the healthcare and political systems of a country, different approaches might have to be taken.

While this paper utilizes the most complex scenario of wellbeing co-creation in its application to healthcare cases, the conceptualization can also be applied to more simple scenarios. For example, looking after one's wellbeing by joining a fitness center where engaged actors, such as trainers account for the health and wellbeing context that surrounds the focal actor. Beyond the challenges the focal actor faces (e.g., low levels of fitness, time constraints, financial constraints), they should evaluate available resources (e.g., fellow fitness enthusiasts). In particular, the focal actor's networks of friends, acquaintances, family, and other types of support might need activation (Hepi *et al.*, 2017) to evoke PO and, ultimately, increase the options for improving the focal actor's wellbeing. This study provides insights into how to manage dynamic processes of PO to co-create wellbeing in terms of initiating, taking, and maintaining psychological ownership. Notably, to facilitate wellbeing, it should be easy to leverage collective resource integration by engaged actors, such as joint activities in a gym or discounts for members who become "co-trainers".

## ***Research Agenda***

The proposed research agenda suggests important areas of inquiry to advance understanding of co-creation, PO, and wellbeing; it reflects the propositions of the conceptual framework, as outlined and summarized in Table 2.

--- Table 2 about here ---

In particular, by taking a PO perspective on co-creation and wellbeing, this study provides insights into emergent research domains that might benefit focal actors, through co-creation of their wellbeing. Relatively little prior research has explored the PO of intangible objects, such as wellbeing, as an intangible target contingent on the type of service (e.g., fitness vs. disease related), situational factors (e.g., fitness level vs. patient's condition), and level of engagement of the patient and other actors (e.g., trainer, physician, nurse, family, friend, social worker) (Fuchs *et al.*, 2010). Explorations of wellbeing co-creation as an intangible target of engaged actors' PO might aid with distinguishing more precisely among wellbeing co-creation (process), wellbeing state (RCE) and SWB (outcome). Furthermore, understanding the impacts which the PO of wellbeing co-creation has on other engaged actors' RCE, and ultimately their own SWB, will be important to help refine these wellbeing constructs. In some cases, an engaged actor (e.g., a grandson) may have formal ownership of the focal actor's (e.g., grandmother) wellbeing, such as in legal guardianships. Outcomes might differ if, for example, an engaged actor (e.g., the grandson as the sole remaining heir) feels "entitled" to take PO over somebody else's (e.g., grandmother) wellbeing. It will be critical to specify the boundary conditions between PO versus a sense of responsibility or accountability. Because PO also indicates a sense of possession, it could be intertwined or

confused with feelings of responsibility and accountability, but distinguishing these constructs can advance understanding of the potential effects on wellbeing co-creation.

Furthermore, PO is influenced by resource conditions, so further studies should determine how an existing pool of cognitive, psychological, physical, and social resources influence co-creation of wellbeing. As noted, PO can have positive outcomes, but it also might result in negative consequences (e.g., territorial behaviors). Further research should explore the resource conditions that tend to lead to the co-destruction of wellbeing.

With regard to the levels of individual PO over wellbeing, it is necessary to consider how the varying levels of PO of engaged actors impact on the focal actor's wellbeing and how this could be measured. It would also be important to address whether this dynamism equally applies to other types of wellbeing, such as financial wellbeing (e.g., inertia towards superannuation). Previous research on PO concurs that both *roots* and *routes* inform its generation (e.g., Jussila *et al.*, 2015). Further research might explore other contextual factors associated with PO (Avey *et al.*, 2009; Mayhew *et al.*, 2007). In professional service settings such as medicine, education and finance, efficacy, identity, and belonging all might be salient factors. Patients, students and financial clients may lack the ability to identify key factors, especially if the target objects, such as a hospital bed, classrooms or superannuation scheme, are undesirable or not psychologically owned by the focal actor. Moreover, the levels of PO applies not just intra-individually but also inter-individually, between a focal actor and other engaged actors. Further study thus is needed to describe intra- and inter-individual variations among different actors in service settings.

Research that goes beyond the PO of individual wellbeing (Jussila *et al.*, 2015) might extend insights into wellbeing and collective PO, such as the collective PO of family members or a medical team that treats a patient. From a system view, the target of collective PO could be expanded, from wellbeing co-creation for an individual actor to national or

ecosystem wellbeing. In a related sense, future research should focus on actors who demonstrate non-ownership of their wellbeing and its effects on fitness regimes, treatment plans, time to heal, or collaboration with medical professionals. Moreover, a measurement of PO levels is needed to investigate when and how much PO changes over time during wellbeing co-creation.

This study thus offers several promising directions for research into the transformation of lives, according to the proposed theoretical framework that combines value co-creation, wellbeing, and PO. It calls for conceiving of value co-creation as more than just a process to generate benefits, wellbeing as more than subjective evaluations by a focal actor, and PO as more than just the notion of possession. Moreover, this study appears timely during periods of worldwide pandemics, such as the COVID-19 crisis, or during other events, such as natural (e.g., earthquakes) or manmade disasters (e.g., terrorist attacks), where the interrelatedness of actors and resource integration becomes very evident. Just think of health and wellbeing aspects during the coronavirus crisis when on the one hand the most vulnerable people are told to self-isolate and not go out of their homes, not even to do grocery shopping. Other people, such as neighbors and family members, can all help out to ensure the person receives all that they need during the crisis. On the other hand, we have situations where people are invited to “coronavirus parties” while social distancing is required or enter shopping malls and supermarkets without wearing gloves or facemasks, putting the collective at risk.

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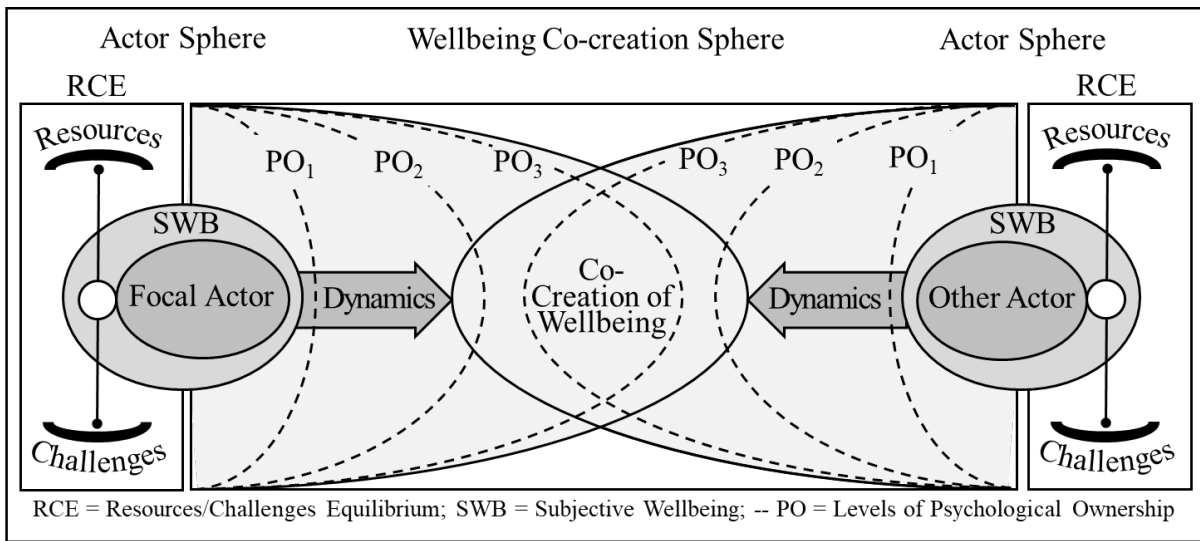


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**Figure 1: Dynamics of Wellbeing Co-creation Framework**



**Table 1: Conceptualizations of Wellbeing**

<b>Authors / Year</b>	<b>Field of Study</b>	<b>Focal Wellbeing Construct</b>	<b>Measure</b>	<b>Definition / Conceptualization of Wellbeing</b>	<b>Theory</b>	<b>Method</b>	<b>Findings</b>
This paper	Service research	Co-creation of wellbeing	Process	A transformative <i>process</i> whereby a focal actor's subjective wellbeing is the <i>outcome</i> of balancing challenges and resources to achieve an equilibrium ( <i>state</i> ), and this depends on the focal actor's and other engaged actors' psychological ownership over the focal actor's wellbeing and subsequent resource integration.	Psychological ownership	Conceptual	Co-creation of wellbeing is dynamic.
Diener <i>et al.</i> (2003)	Social psychology	Subjective wellbeing (SWB)	Outcome	Personal outcome whereby a person thrives across multiple domains of life.	Dimensions of SWB: physical, psychological, social, existential	Review	If a person's life exceeds comparison standards, the person is satisfied and happy. If the life falls short of comparison standards, the

							person is dissatisfied and unhappy.
Diener <i>et al.</i> (2015, p. 234)	Social psychology	Subjective wellbeing (SWB)	Outcome	“People’s evaluations of their lives—the degree to which their thoughtful appraisals and affective reactions indicate that their lives are desirable and proceeding well.”	Affective and cognitive bases of wellbeing.	Review	SWB is based on emotional reactions to events and cognitive judgments of satisfaction and fulfillment in life.
Dodge <i>et al.</i> (2012, p. 230)	Positive psychology	Resources/challenges equilibrium (RCE)	State	“The balance point between an individual’s resource pool and the challenges faced” includes cognitive, psychological, physical, and social resources and challenges.	Dynamic equilibrium theory of wellbeing	Conceptual	Individuals are decision makers, with choices, preferences, and the possibility of becoming masterful or efficacious.
Kahnemann <i>et al.</i> (1999)	Hedonic psychology	Hedonic wellbeing	Outcome	Hedonic wellbeing is what makes experiences in life pleasant or unpleasant, through the consideration of feelings, circumstances,	Experiential	Experiment	Experiences in real-time rather than retrospective evaluations of

				enjoyment, and suffering at a particular time or phase in one's life.			life provide richer insights into true wellbeing and happiness.
Keyes <i>et al.</i> (2002)	Social psychology	Psychological wellbeing (PWB)	Outcome	PWB is distinct from SWB, concerned with human development and existential challenges of life, including resources and potential to cope with adverse life events.	Human development and existential challenges of life.	Survey, quantitative, factor analysis	The probability of optimal wellbeing (high SWB and PWB) increased as age, education, extraversion, and conscientiousness increase and as neuroticism decreases.
Ryan and Deci (2001)	Humanistic psychology	Eudaimonic wellbeing	Outcome	Wellbeing is optimal psychological experience and functioning, viewed from two perspectives: hedonic (presence of positive and absence of negative affect) or	Aristotle	Survey	Wellbeing is not an outcome or end state as much as a process of

				eudaimonic (living life in a deeply satisfying way).			fulfilling or realizing daimon or true nature—that is, fulfilling virtuous potential and living as inherently intended.
Seligman (2011)	Positive psychology	Flourishing, languishing	Process	The gold standard for wellbeing is flourishing, and the goal of positive psychology is to increase it.	PERMA (positive emotion relationships meaning affect)	Experiment, quantitative	Exercises focused on building gratitude, increasing awareness of what is most positive about the self, and identifying strengths of character.



**Table 2: Research Agenda for Wellbeing Co-Creation and Psychological Ownership**

<b>Propositions</b>	<b>Areas of Inquiry</b>
P1: Engaged actors' psychological ownership.	<ul style="list-style-type: none"><li>▪ How are a sense of entitlement and formal ownership connected?</li><li>▪ How does the PO of wellbeing apply to different types of wellbeing?</li></ul>
P2: Interrelated routes to psychological ownership.	<ul style="list-style-type: none"><li>▪ What are the contextual factors associated with PO?</li><li>▪ How does PO vary intra- and inter-individually across focal actors and engaged other actors?</li><li>▪ What are the boundary conditions between PO and feelings of responsibility or accountability?</li></ul>
P3: Levels of psychological ownership.	<ul style="list-style-type: none"><li>▪ How are collective PO and wellbeing intertwined?</li><li>▪ How does perceived non-ownership influence wellbeing?</li><li>▪ How can PO Levels be measured and how much do they change?</li><li>▪ How do the varying levels of PO of engaged actors impact on the focal actor's wellbeing? How can this be measured?</li></ul>
P4: Psychological ownership and resource integration.	<ul style="list-style-type: none"><li>▪ How do different resource conditions in an actor's resource pool influence a change in PO and wellbeing co-creation?</li><li>▪ How do co-creation and co-destruction of resources and interactions influence wellbeing?</li><li>▪ How are engaged actors' wellbeing states and SWB affected?</li></ul>

## Appendix 1: Key Terms

<b>Key Term</b>	<b>Definition</b>	<b>Reference</b>
Focal actor	The actor at the center of wellbeing efforts.	This paper
Engaged actor	Any other actor involved in the improvement of the focal actor's wellbeing.	This paper
Psychological ownership	A sense of possession that may be distinct from any legal right of ownership.	Pierce <i>et al.</i> (2003)
Healthcare	"Collection of goods and services that are perceived as bearing a special relationship to health ... [and are] central to the health [and wellbeing] of both individuals and populations"	Evans and Stoddart (2017, p. 27)

## **Appendix 2: Three Types of Healthcare Practitioner–Patient Relationships**

This appendix outlines the development of healthcare practice, particularly the healthcare practitioner–healthcare customer relationship over time, from the traditional notion in healthcare practice to approaches such as self-managed care and shared decision making (McColl-Kennedy *et al.*, 2017b), and more recently moving towards the development of “person- and people-centred healthcare” (PPCHC) (Lukersmith *et al.*, 2016).

### ***Traditions in Healthcare***

Traditionally, interactions between the focal actor and the healthcare practitioner tend to focus on the problem, not the person (Courtney *et al.*, 1996). In their role as the focal actor’s guardian, the healthcare practitioner authoritatively determined what was best for the focal actor. The focal actor, to a large extent, was viewed as a passive recipient of care (Wagner *et al.*, 2005). The healthcare practitioner used their knowledge and skills to determine, diagnose and make decisions about treatment and interventions (Emanuel and Emanuel, 1992). In this form of healthcare we can presume that the healthcare practitioner had PO over the focal actor’s health, while the focal actor often felt that their wellbeing was owned by the healthcare practitioner. The wellbeing of the focal actor, therefore, depended on whether the healthcare practitioner’s resource integration ability was sufficient to cure the focal actor, and whether the focal actor felt that the healthcare practitioner had taken PO over their wellbeing.

### ***Self-Managed Care***

Self-managed care refers to an “individual’s ability to manage the symptoms, treatment, physical and psychosocial consequences and lifestyle changes inherent to living with a chronic condition” (Barlow *et al.*, 2002, p. 177), both inside and outside the healthcare setting. The core self-management skills include problem-solving, decision-making, resource utilization, sharing of information, and forming patient–healthcare provider partnerships

(Lorig and Holman, 2003). The role of healthcare professionals in self-managed care is educating the focal actor about their disease and teaching self-care skills, forming relationships (with patients, families, and communities), and facilitating self-care and peer education (Lorig and Holman, 2003). We therefore reason that self-managed care could potentially build a focal actor's PO over their wellbeing. However, if the challenges are much larger than the resources available or the burden of self-care is too great the focal actor's PO of their wellbeing may diminish and self-managed care may not be satisfactorily achieved. In such cases, neither the focal actor nor the healthcare practitioner has PO of the focal actor's wellbeing, and this diminishes the chances of successful health outcomes for the individual.

### ***Shared Decision-Making***

Subsequently, shared decision-making (SDM) emerged from the increased interest in more person- and people-centred healthcare (PPCHC) (Lukersmith *et al.*, 2016). SDM is considered a mutual process whereby the focal actor actively engages in medical consultations, defines their preferred role in decision-making, forms a partnership with the healthcare practitioner, articulates health problems and expectations, communicates, accesses and evaluates information, and negotiates and agrees on an action plan (Frosch and Kaplan, 1999). The healthcare practitioner, in turn, must be willing to establish a relationship with the focal actor and take the time to understand their preferred role in decision-making, share expertise and evidence, identify choices, respond to their ideas and concerns, and discuss options (Charles *et al.*, 1997).

SDM and a PPCHC approach are therefore likely to evoke a healthcare practitioner's PO over a focal actor's wellbeing, and once their preferred role is successfully understood and developed, PO over their own wellbeing should emerge. When the level of PO of both actors is high, their resource integration in terms of improving the focal actor's wellbeing and co-created wellbeing is at an optimal level. In contrast to traditional healthcare and self-

managed care approaches, PPCHC and SDM have the potential to create shared PO among healthcare practitioners and their customers over the focal actor's wellbeing, thus contributing to positive co-created wellbeing. This paper bases its conceptual explorations on the notion of the development of PO through PPCHC and SDM.