Salutogenic-Oriented Mental Health Nursing: Strengthening Mental Health Among Adults with Mental Illness

Nina Helen Mjøsund and Monica Eriksson

Abstract

This chapter focuses on mental health promotion with a salutogenic understanding of mental health as an individual's subjective well-being encompassing both feelings and functioning. Mental health is an ever-present aspect of life, relevant for everybody; thus, to promote mental health is a universal ambition. Our chapter is written with adults with mental illness in need of mental health nursing in mind. To understand the present and make suggestions for the future, knowledge of the past is needed. We elaborate on historical trends of nursing, nursing models, and the hospital setting to support our statement; persons with mental illness need a more complete mental health nursing care, including salutogenic mental health promotion. In the last part of the chapter, we introduce the salutogenic-oriented mental health nursing, and further showing how salutogenesis can be integrated in nursing care for persons with

mental illness. As well as elaborating on the features of salutogenic-oriented mental health nursing, and briefly present the Act-Belong-Commit framework for mental health promotion as an example of salutogenesis in nursing practice.

Keywords

Act-Belong-Commit · Mental health · Mental illness · Mental health nursing · Mental health promotion · Nursing models · Psychiatric nursing · Salutogenic-oriented mental health nursing · Salutogenesis

N. H. Mjøsund (✉)
Division of Mental Health and Addiction,
Department of Mental Health Research and
Development, Vestre Viken Hospital Trust,
Drammen, Norway
e-mail: nina.helen.mjøsund@vestreviken.no

M. Eriksson
Department of Health Sciences, University West,
Trollhattan, Sweden
e-mail: monica.eriksson@hv.se

15.1 Introduction

We aim to use our own experiences to guide the presentation in this chapter. For me, Nina, the first author of this chapter, the occupational and professional life has been a journey of transformation from a nurse educated in psychiatric nursing, mental disorders, symptoms, and risk factors to find my identity as a *mental health nurse*. Today I am intrigued by the constitutional characteristic of resources and strengths in human beings, which of course also applies to persons with mental illness. These values, beliefs, and my respect for persons struggling with mental disorders are grounded in experiences acquired

at wards in hospital settings. The majority of my training gave prominence to the traditional role of caring for the sick. The opportunity to be educated in public health and health promotion was a turning point to embrace an expanded role as a “mental health nurse.” In this journey, Monica has been an excellent guide into the theoretical landscape of salutogenesis.

For me, Monica, the second author, salutogenesis has been my research interest from the very beginning and up to date, more than 30 years of education and research. As a former social worker at a hospital and with work experiences among disabled people, my focus has always been on peoples’ resources and their ability to overcome difficulties. Aaron Antonovsky and his salutogenic theory and model of health gave me the knowledge and prerequisites to immerse myself in what leads to health instead of the causes of illness.

Together we, Nina and Monica, share the desire to enhance the prerequisite for strengthening mental health of persons in need of hospitalization in mental health care. Salutogenesis has become the air we breathe. We possess extensive experiences from close collaboration with persons living with severe mental disorders in projects, both in health research and in clinical quality enhancement projects. We pay tribute to service user involvement. Thereby, this chapter emphasizes an insider perspective on how mental health promotion is perceived grounded in patients’ lived experiences.

An elaboration of the salutogenic orientation applied on health and mental health clarifies the main theoretical underpinning in this chapter. Until we have arrived at explaining the content and application of salutogenic-oriented mental health nursing, we start with our understanding of health in general and mental health in particular. We continue to explain what we mean by salutogenic mental health promotion. The difference between interventions aiming for health promotion and the prevention of disorders will further be elaborated.

The promotion of mental health for people with mental illnesses is an issue for the nursing workforce all over the world. People who live with mental disorders deserve support to cope and recover from their illness as well as support to strengthen their general health. We claim that the population with mental disorders is in great need of *health promotion* interventions including the improvement of physical, social, spiritual, and mental health, due to 15–20 years shorter life expectancy compared with the general population [1]. However, the focus in this chapter is on salutogenic *mental health promotion*.

To understand the present and the future, knowledge about the past is needed. Thus, we highlight elements from some widely used nursing theories, which several decades ago brought health promotion and health maintenance into nursing science. Building on nursing theories, salutogenesis, and knowledge of the essence of health in general and mental health in particular, we end up with a proposal for a more holistic and coherent nursing care, including both *salutogenic-oriented nursing*, and *pathogenic-oriented nursing*. In order to emphasize the significance of salutogenic mental health promotion in nursing practice, we describe features of the salutogenic-oriented mental health nursing, and its application in clinical practice in mental health services.

15.1.1 Methods

The choice of theoretical perspectives, models, interventions, and evaluations presented in this chapter have been influenced by the usefulness for performance of clinical nursing and health care in the specialized health care services. Further, this chapter emphasizes an insider perspective on how mental health promotion is perceived grounded in patients’ lived experiences. The chapter is inspired from our own empirical research [2–7], as well as extensive theoretical analysis and review reports [8–14]. The litera-

ture we build on is mainly grounded in qualitative research. More common in the field of public health as well as in medicine dominated hospital settings are the observational data and quantitative research.

Theoretically we rely on two salutogenic health theories, the salutogenic theory by Antonovsky [9, 15, 16] and mental health as flourishing by Keyes [17–20]. Additionally, the presentation was substantiated with a literature search including the words health care, health promotion, mental health promotion, mental health care, mental illness, mental disorders, nursing, salutogenesis, and service user involvement. The examples in this chapter are drawn from the context of the Nordic countries, as this is where we, the authors, are educated, have our work experience, and are living.

15.2 Health in Salutogenic Theoretical Framework

Salutogenesis offers a resource-oriented and strength-based perspective on health, and we will therefore especially emphasize some aspects of the existing knowledge base.

15.2.1 Health

Everyone's health gets affected. Health is a fundamental part of human beings. However, what constitutes the quality of health might be perceived differently. The authors of this chapter share a common understanding of the concept of health, i.e. health is always something positive, something we want more of, and want to promote and protect. A salutogenic approach to the study of health focuses on the genesis or sources of health, as well as circumstances promoting or undermining health. A salutogenic orientation includes a broad focus on resources, assets, and strengths leading to positive outcomes, which is different from the more limited focus in Antonovsky's [16] *Model of health*. Antonovsky

(1979) explained health as a movement along a continuum between ease and dis/ease,¹ and rejected the dualism of the health–disease dichotomy. Health promotion is about the movement towards health, with emphasis on assets, actions, and interventions that aim to promote health as a positive outcome. Adult lay people in Norway conceptualized health by six essential elements: well-being, function, nature, a sense of humour, coping, and energy [21]. In the same study, health was characterized by three qualities; *Wholeness*: health is a holistic phenomenon. Health is related to all aspects of life and society. *Pragmatism*: health is a relative phenomenon. Health is experienced and evaluated according to what people find reasonable to expect, given their age, medical condition, and social situation. *Individualism*: health is a personal phenomenon. Every human being is unique, and health and strategies for health must be individualized [21]. It has also been shown that nurses in mental health services perceived health as more than the absence of disorder [22].

15.2.2 Mental Health

No health without mental health—indicating a discourse including mental health in a positive sense [23]. Antonovsky [24] described mental health as a continuum. A person's location on a mental health continuum included the presence of a positive aspect, a sense of psychological well-being. Antonovsky defined mental health as more than the absence of something negative:

Mental health, as I conceive it, refers to the location, at any point in the life cycle, of a person on a *continuum* which ranges from excruciating emotional pain and total psychological malfunctioning at one extreme to a full, vibrant sense of psychological wellbeing at the other [24], p. 274].

¹In Antonovsky's original writings he consequently used a hyphen between dis and ease describing the health continuum as ease–dis-ease; however, according to programs that automatically correct misspelled words the hyphen often disappears, therefore, in this chapter we will use a slash; ease-dis/ease).

A salutogenic orientation focuses on the achievement of a successful coping, which facilitates movement towards that part of the mental health continuum that is a vibrant sense of psychological well-being. Mittelmark and Bull [25] show passages by Antonovsky indicating that his understanding of health was an aspect of the broader construct of well-being.

Inspired by salutogenesis, the research of Corey Keyes [17] focuses on subjective experiences of mental health. Keyes views mental health as the presence of positive states of human capacities and functioning in cognition, affect, and behavior. In line with Antonovsky, Keyes also questioned the commonly accepted definition of mental health as the absence of psychopathology. As elaborated in Chap. 5, Keyes describes mental health as the presence of psychological and functional well-being, thus a positive experience, not the absence of infirmity. He labels a continuum and uses the term *flourishing* to describe high quality of mental health or the most appealing position on the mental health continuum. The opposite position is labeled *languishing*, with moderate mental health in-between. Keyes [26] argues that it is not enough to see how people react. We also need to know how they feel and how they perceive their world. Mentally healthy people are described as being content with who they are and what they have, they feel socially and mentally competent, and emotionally stable [26]. Further, mentally healthy people experience to be generally happy, enthusiastic, and energetic most of the time, as well as being able to cope with problems and crisis in life [27].

Mjøsund et al. [6] used the salutogenic framework as the theoretical foundation for studying how persons with severe mental illness perceived their world of mental health. The study participants were not talking about absence of illness or disorder symptoms in their descriptions; they claimed mental health was an aspect of being, that was always present and experienced

in everyday life as a sense of energy. Health was not perceived as changeless, but as a fluctuating and dynamic phenomenon. The participants perceived mental health as a movement, like walking up or down a spiral staircase, equivalent to a continuum [6], as illustrated in Fig. 5.2 in Chap. 5.

15.2.3 Mental Health Promotion

In the field of mental health promotion, it is essential to reflect on the understanding of health and mental health, as well as how promotion relates. WHO [28] states that mental health promotion involves actions that improve psychological well-being. Mental health promotion is a contested term and might be enlightened from multiple perspectives [29, 30]. Salutogenic health promotion is an endeavor to promote health by actively and consciously focusing on strength and resources in people. Mental health promotion can be explained as activities to sustain, restore, and enhance mental health. Mental health promotion might be applied on a policy and societal level, as well as on an individual, family, group, and community level. Salutogenic mental health promotion is directed towards improving, strengthening, or increasing the well-being of all people regardless of mental illness or not. Interventions designed to enhance mental health and well-being by increasing the coping capacities of communities and individuals and by improving environments that affect mental health are also described as mental health promotion [27]. The goal for health promotion in society and on a population level should be to make health promoting behaviors easier and more likely, and simultaneously make health-depleting actions more difficult. In this chapter, salutogenic mental health promotion is explored by focusing on strength and resources at an individual level in mental health care settings.

15.2.4 The Salutogenic Model of Health

Aron Antonovsky (1923–1994) challenged the conventional paradigm of pathogenesis and its dichotomous classification of persons as being either healthy or diseased [16]. He coined the concept of salutogenesis, which means the origin of health. Antonovsky saw health as a movement along a continuum on a horizontal axis between health/ease and dis/ease (see Fig. 15.1) [10]. He saw the relationship between the two orientations—pathogenesis and salutogenesis—as complementary [15].

This model of health within the salutogenic framework is resource-oriented focusing on peoples' ability to manage stress and still stay healthy. Salutogenesis is a way of thinking, being, acting, and meeting people in a health promotion manner [10]. It is not a personal trait or a special personality, but a life orientation or a way of viewing life as comprehensible, manageable, and meaningful [31]. More generally, salutogenesis refers to a scholarly orientation focusing attention to the origins of health and assets for health, contra the origins of disease and risk factors [32]. The core resources to counteract stressors are the sense of coherence (SOC) and generalized and specific resistance resources (GRRs/SRRs) and deficits (GRDs/SRDs) [15, 31, 33, 34]. SOC is defined as:

“a global orientation that expresses the extent to which one has a pervasive, enduring though dynamic feeling of confidence that: (a) the stimuli from one's internal and external environments in the course of living are structured, predictable and explicable; (b) the resources are available to one to meet the demands posed by these stimuli; and (c) these demands are challenges, worthy of investment and engagement” [15, p. 19]

SOC includes three core dimensions: (a) comprehensibility, which refers to the extent to which one perceives the stimuli that confront one as consistent, structured, and clear; (b) manageability, which is the extent to which one perceives that the resources at one's disposal are adequate to meet life's demands; and (c) meaningfulness, which refers to the extent to which one feels that life makes sense emotionally ([15], p. 16–18). How the core dimensions interact and together influence SOC is illustrated in Fig. 15.2. The cognitive dimension comprehensibility is illustrated with a thought bubble over the face to draw attention to a capacity to judge the reality, to understand what is happening. The hand illustrated under manageability draws attention to the instrumental or behavioral dimension, a practical capacity to manage the situation. The heart

Fig. 15.1 The health continuum “ease/dis-ease” (Published with permission from Folkhälsan Research Center, Helsinki, Lindström & Eriksson [3])

Fig. 15.2 The dimensions of the sense of coherence

under meaningfulness draws attention to which one feels that life makes sense emotionally, that the challenges in life are worth investing energy in, and are worth our commitment and engagement. The arrows around the dimensions help us to remember that these dimensions are involved when individuals are in interaction with the environment as they constantly go through challenging situations.

GRRs provide a person with sets of resources to promote meaningful and coherent life experiences. GRRs are found in people and bound to their person and capacity, but also to their immediate and distant environment [15, 33]. SRRs are context and situation bounded. Through SOC the GRRs enable one to recognize, pick up, and use SRRs in ways that keep tension from turning into debilitating stress [34]. Salutogenic nursing interventions aim to aid the patients to be aware, and use their GRRs/SRRs.

The Global Working Group on Salutogenesis (GWG-Sal) has identified key avenues for future development of the concept of salutogenesis to create a sound scientific base of health promotion [35]. There is a need to advance the original salutogenic model of health by adding an additional positive health continuum operating independently of stressors, as well development of alternative approaches to the conceptualization and measurement of the SOC [35].

15.3 Setting: The Patients' and the Nursing Context

The population discussed in this chapter is persons diagnosed with mental disorders receiving nursing and health care services in specialized mental health care.

15.3.1 Persons with Mental Disorders

People experiencing mental disorders are just as different as anyone else is. The understand-

ing of mental disorders are influenced by time and culture, and the use of terminology associated with disease is complicated and contested [36–38]. Dominant diagnostic systems in the field of psychiatry use different terminologies, the ICD-10 [39] uses classification of diseases and the DSM-5 [40] uses classifications of disorders. Severe conditions of mental disorders often broadly include disorders in the bipolar and schizophrenia spectrums, and complex comorbid conditions with substance abuse disorders, as well as life-threatening depressions. Severe conditions often persist over time and contribute to serious difficulties in personal and social functioning, thereby reducing the affected person's quality of life [41].

The experiences of mental distress, problems, and mental disorders are common and often underreported. According to an EU survey, one third of Europeans suffers from mental, neurological or substance abuse diagnoses (prevalence) [42]. Nordic patients with mental disorders seem to have 15–20 years shorter life expectancy than the general population largely due to lifestyle-related noncommunicable diseases [43]. A systematic review and meta-analysis [44] showed that people with schizophrenia are associated with at least 14 years potential life lost. To reduce this mortality gap, the situation requires urgent development and implementation of interventions.

We do not underestimate the fact that persons with mental disorders are in great need of lifestyle interventions targeting behavior to prevent somatic illnesses and to improve their physical health. However, less attention seems to be on behavior related to strengthening mental health. We realize that in clinical practice, it is difficult, nor desirable, to separate initiatives to promote physical, social, spiritual, or mental health. However, theoretically, in publications and in compilation of knowledge it can be relevant to shed light on certain parts of a larger context. Here, we aim to elaborate on one part of a larger picture, which is salutogenic mental health promotion for persons with mental disorders.

To avoid confusion with Antonovsky's ease-dis/ease terminology we avoid the use of the word disease. To denote a diagnosed condition we use the term *mental disorder*. When focusing on the individual experiences of struggling with mental problems or living with a diagnosed condition we use the term *mental illness*.

15.3.2 Nursing in the Context of Mental Health Care

Traditionally, mental health nursing and health care in hospitals have been directed towards persons diagnosed with a mental disorder or a suspected mental disorder. The main issue for nursing is the consequences of the disorder and coping in daily life. Hospitalized patients are often individuals with severe, multiple, and complex needs and long-term conditions. The impairment of self-care and disturbance of daily activities, as altered sleep pattern, bad nutrition, inactivity, strained relationships, and use of drugs in combination with increased intensity of symptoms of the disorders might require hospitalization. Patients affected with a severe mental disorder might be in great need of nursing; acute episodes might require total and lifesaving care. Nurses must apply their comprehensive knowledge about mental disorders to assist the patients to cope with consequences of the individual illness in daily life. User-led qualitative research revealed that individuals with complex needs appreciate trusting relationships with professionals, within a positive framework that fosters self-belief and which is focused on salutogenesis rather than pathogenesis [45].

A large part of the global nursing workforce, practices within primary and secondary health care settings in a rehabilitation, residential, or community setting. This workforce is claimed to be a sleeping giant in health promotion [46]. Promotion and maintenance of mental health, beyond the responsibility to provide curative services for adults with severe mental illnesses,

do not get the attention they deserve by nurses and other health professionals in the health care sector. Nurses are in a unique position for health promotion due to their presence in services across society, their continual attendance with patients night and day, and the close relationships they often develop with patients and next of kin. Nurses constitute a powerful group when wanting to reach and impact a large part of the population.

Besides somatic treatment and psychotherapeutic interventions, treatment for patients with severe mental illness should also include psychosocial interventions [41]. Berg and Sarvimäki [47] introduced a holistic-existential approach to health promotion in nursing. They defined health promoting nursing as "planned nursing actions designed to meet the needs of individuals, families and communities in their efforts to deal or cope with health challenges that they presently encounter in daily life or that might appear in the future... The aim of nursing is to support human beings in their need of knowledge and to offer practical assistance in order to cope with illness experiences and suffering and, thus, to stimulate healthy living" ([47], p. 390).

15.3.3 Health Promotion in the Specialized Mental Health Care Services

Despite launching the Ottawa charter nearly four decades ago [48], and the messages reinforced in the New Haven recommendations [49], hospitals all over the world are still characterized mostly by a pathogenic and biomedical approach. Psychiatric treatment and care of patients in mental health care hospitals are dominated by diagnosing, treating, and caring for persons with severe episodes of mental disorders, as well as acute and lifesaving interventions. Both nursing and medical interventions are often introduced with rather acute and short-sighted perspectives, putting the long-term focus of health promotion

and quality of life in the shadow. A reorientation of the health care services is stated to be the least systematically developed, implemented, and evaluated key action area outlined in the Ottawa Charter [50], and new ways to reorient the health services towards the promotion of health are requested [51, 52]. The reorientation of the health care system is also requested by patients with mental disorders [3]. The timing for health promotion seems to be good during hospitalization when the awareness of health is heightened [53]. Former inpatients have described the hospital admission as a *window of opportunity* for choosing a healthier way of living, with the help of all the (human) resources available under hospitalization [5].

The role of nurses in the hospital is undergoing transitions, including redefining aspects of professional work, more complex and complicated conditions and acute crises as well as changing reimbursement systems [54, 55]. The scene has changed and other health care providers such as psychologists, social educators, social workers, psychiatrists, and counselors overlap with the nurses in mental health care hospital settings. This situation might cause controversies and role confusion in everyday life at the workplace. To define the scope of nursing as well as the other professions and to promote distinct roles of mental health nurses and other professions will be important for future development of these services.

15.3.4 Towards a More Complete Mental Health Nursing

We want to argue for a development towards a mental health nursing science and practice that more explicitly includes knowledge from salutogenesis. We do not claim this is a new approach, as many years ago, the salutogenic model was claimed to be suitable for adaptation in nursing milieu [56, 57]. Salutogenic-oriented mental health nursing is rather a conscious application of health promotion, based on beliefs about the human potential, intertwined in interventions to

increase coping, competences, good feelings, and well-being. Our aim is to promote a nursing practice based in salutogenic thinking, feeling, and acting. Antonovsky saw early the potential in nursing to become an important profession to promote a salutogenic orientation. In the preface of his second book he said: *In writing this book, I have also had another group in mind: nurses, going through the fascinating throes of formulating a new professional identity, are perhaps more open to my ideas and ways of thinking than almost anyone else* ([15], p. xiv).

Our vision is to contribute to a more complete mental health nursing practice, where an illness and disorder-oriented approach are complemented with a health-oriented approach based on salutogenesis. For the understanding of salutogenic-oriented mental health nursing, we want to clarify the distinction between a salutogenic versus a pathogenic orientation. We explain the different meanings of treatment and prevention of disorders and disability, on to *protect and maintain* mental health, as well as the understanding of *promotion* of health, including physical, social, spiritual, and mental health. There are differences between these concepts, which have significance for how to work in different contexts. Our suggestion is explicitly to include salutogenic mental health promotion in nursing practice. Nurses should utilize salutogenic knowledge to emphasize the persons' level of mental health and initiate health promoting interventions, alongside a focus on the status of mental illness in planning these nursing interventions. We claim that nursing in mental health care services should include two complementary purposes in their portfolio; a health-oriented and an illness-oriented approach, as illustrated in Fig. 15.3.

Figure 15.3 illustrates the combination of knowledge from both salutogenesis and pathogenesis, as the base for promotion and protection of health, as well as the treatment and prevention of disorders. The knowledge base of salutogenesis in partnership with the knowledge base of pathogenesis complements each other, as well as contrasts each other by different area of interest

Fig. 15.3 Aims, knowledge base, and focus of a more holistic mental health nursing

[8, 58–60]. Our message is underlined by Becker and Rhynders’ [61] use of mathematic analogy: “Pathogenesis is about subtraction and how to take away bad conditions, risk factors, or threats. Salutogenesis, on the other hand, is about addition and how to add positive actions, opportunities, conditions, and outcomes” [61, p. 2].

Antonovsky [62] described similarities and differences between the two paradigms and argued for salutogenesis as a more powerful guide for health promotion research and practice than the pathogenesis. A pathogenic orientation embraces a dichotomous classification of disease or absence of disease. Pathogenesis assumes that if nothing causes mental illness, good mental health will be manifest. Antonovsky [16] followed a continuum line of thought in his salutogenic model of health. The health continuum contains an end of ease where you aim to stay and to protect your position, as well as an adverse end of dis/ease from which you want to leave. Both paradigms have a focus on factors; salutogenesis on salutary factors that promote health and pathogenesis on risk factors that might cause disorders. Taking a point of departure in salutogenesis helps nurses relate to all aspects of a person using a holistic approach. Within the pathogenic paradigm, a more reductionist approach leads to a focus on a particular diagnostic category [62].

Moreover, the desired positive outcomes are different in these two paradigms. Within a salutogenic way of working, the anticipated outcome is to have more health and well-being. Inspired by salutogenesis, the aim is to create progress towards desired improvements and gains and protect against something that may cause regression of health. This is the realm of promotion. In contrast, to be working within a paradigm of pathogenesis where the anticipated outcome is no disease, the emphasis will be on a problem. The best possible outcome from a problem is the lack of a problem, i.e. no symptoms of a mental disorder. A more complete mental health nursing practice requires knowledge from both paradigms.

To understand the present and the future, we need to understand the past. Thus, after giving the theoretical contextualization of mental health nursing we proceed forward to explain the work of influential nursing theorists. In the next section, we highlight some nursing theories, which have contributed substantially to the nursing science of today. Their work might help us to a) differentiate the role of nurses from other health care professionals by delineating the unique focus of nursing, and b) facilitate a reorientation of the nursing practice to include an explicit focus on salutogenic mental health promotion.

15.3.5 From Nightingale to Keyes: The Foundation for Salutogenic-Oriented Mental Health Nursing Care

Standing on the shoulders of giants is a metaphor to draw attention to the importance of building on existing knowledge. Standing on a foundation of knowledge makes us able to visualize the future and make theoretical suggestions to improvements in clinical practice. First of them all, Florence Nightingale [63] claimed that the aim of nursing were to promote the body's ability to heal and recover itself. Nurses should facilitate the healing processes by caring for a proper selection and administration of a diet, fresh air, light, warmth, cleanliness, and hygienic conditions, and reduce unnecessary emotional stress as well as carefully observe the patient's condition. Nightingale [63] believed that the patient in their environment was the main focus for nurses. Nightingale claimed that nursing was to care for the basic needs of human beings and promote health and well-being. Inspired by a salutogenic approach, we argue that Nightingale was the first health promoter in nursing science with her focus on promoting health and well-being of her patients.

Another influential nursing theorist for mental health nursing was Virginia Henderson. In her book "the Nature of Nursing" [64], she defined the unique function of nursing as to assist the person in performing activities contributing to health or recovery that the individual could have performed themselves if they had the strength, the will and knowledge, and always with the aim to help them gain independence as rapidly as possible [64]. Both Nightingale and Henderson saw nursing acts as assisting or doing on behalf of the patient, but never doing more than the patient can do independently or by supervision. This tuning towards the patient's mental and physical condition and environmental situation was the essence of the art of nursing. It was crucial to empower the patient to self-care as soon as possible. Seeing the patients as part of a greater society, always in interaction with their environment contributed to a broader view

and holistic nursing, which were what persons with mental disorders also demanded and appreciated [2, 6].

Dorothea Orem claimed that the proper focus of nursing was self-care [65]. Her *Self-Care Deficit Nursing Theory* has similarities to those of Nightingale and Henderson, but Orem increased the emphasize on achieving health by the individual's ability to care for themselves [65]. According to Orem, self-care was activities that the individual performed on their own to maintain life, health and well-being. Normally, adults care for their own needs, so the human ability for engaging in self-care was termed self-care agency. Infants, children, the aged, the ill or the disabled required nursing in form of complete care or assistance with self-care activities in their day-to-day living [65]. Self-care contributed to human functioning and development based on self-care requisites in three categories: (a) universal, (b) developmental, and (c) conditions of illness, disorder, or injury [65]. The category of universal self-care requisite includes resources vital to the continuation of life, to growth and development, as such as air, food, water, elimination processes, activity and rest, social interaction and solitude, as well as human well-being. The developmental requisite comprised conditions to support life processes and needs related to various stages of development in the life course. The last category of requisite was related to situations of disorders or injury. There was a need to seek appropriate medical assistance for conditions of human pathology and carry out medical prescribed treatments, caring for side effects of the treatment, as well altering one's life-style to promote personal development while living with the side effects of pathology and medical treatments such as medicine.

The self-care deficits delineated when nursing was needed, and a nurse-patient relationship was required. Where the nursing relationship was not limited to just one individual, but the receiver of nursing care could be a family, a group or communities. The roles of the nurse and the patient were complementary in that a certain behavior of the patient elicited a certain response in the nurse, and vice versa. A self-care deficit requires

nursing activities. The self-care concept facilitates an involvement of the patient in the nursing planning, prescribing, providing and evaluating. A model of practice termed *Treating Self-Care Deficits Related to Mental Health Functioning* has been developed as part of a mental health nurse practitioner master's program grounded in Orem's model [66].

Katie Eriksson's theory of *caritative caring* has been influential in nursing and other caring professions in the Nordic countries [67]. In her philosophical theory of caring, Eriksson claimed that the basic motive, the substance and the distinctive character for caring were *caritas*, which was by nature unconditioned love. In a health promotion context, it is appropriate to highlight her concept analysis of health [68]. She defined health to be constituted by two dimensions; the objective dimension of soundness and freshness and the subjective dimension of well-being. Health was seen as more than the absence of illness, and was conceived as movement and integration, *a becoming*. Eriksson [68] illustrated the health dimensions in a crosshair which included a vertical line representing the subjective dimension of well-being, and a horizontal line which represented objective dysfunctional attributes.

15.3.6 Towards a Distinct Understanding of Mental Health in Mental Health Nursing

In the nursing science we see traces on health promotion already in Nightingale's work [63] when she claimed long ago that nursing is to promote health and well-being for the patients. Also Henderson [64] argued that the aim of nursing was to contribute to health and Eriksson [65] claimed health to be more than the absence of illness. As one of many nursing theories we judge the conceptual framework of Orem [65] to be highly compatible with a salutogenic orientation. We want to inspire mental health nurses and other health professionals working with persons with mental disorders to build on

former nursing giants to apply health promotion more explicit in their clinical practice. The reason for this is based on knowledge we possess about contemporary clinical practices, the population in focus, and international guidelines as the Ottawa charter [69], as well as the fact that persons with mental disorder demand more health promotion [3].

To be able to develop, implement and measure the outcome of mental health promotion initiatives, we need to make overt the applied definition of mental health. Rather than arriving to a consensus on a definition of health for the use in the total field of health promotion, Mittelmark and Bull [25] argue for a pragmatic approach where scientist and health promoters make overt which definition they use in different project and settings.

Antonovsky's [15, 16, 62] work on salutogenesis and health promotion is essential for nursing and health promotion. However, we claim that his definition of health as a continuum between ease and dis/ease is not sufficient. A close reading of Antonovsky's writings gives no indication that he separated health from disease. Further, several passages of his writing might be understood as he included disorders and similar conditions in the dis/ease pole of the health continuum. Antonovsky [15] defined the positive end of the continuum in a negative way by the focus on the absence of pain, functional limitations, acute or chronic prognosis and health-related action implications [35]. See also discussion in the Handbook of Salutogenesis, chap. 49 [70].

Katie Eriksson [68] gave an important contribution to the understanding of health through her concept analysis. She included by her health definition an objective dimension representing symptoms of disorder or objective dysfunctional attributes, together with a subjective dimension of well-being. Later, and even more specific, we again can find a subjective dimension of well-being in a mental health definition. Keyes [20] defines mental health as an individual's subjective well-being, in term of their affective state and their psychological and social functioning, and good mental health is described by the metaphor flourishing (see Chap. 5 for a thoroughly elaborated

tion of Keyes work). Besides Keyes' work on a definition of mental health [20], he has also given important contribution to the field by his two continua model of mental health and mental illness in the same context or picture (see Fig. 5.4). This complete picture is helpful for nurses and health promoters working with adults living with a mental disorder by making it possible to hold both of these phenomena in mind at the same time. In the setting of mental health nursing, based on the elaboration and assessment of the theoretical models and conceptual frameworks presented in this chapter, we suggest applying a distinct definition of mental health encompassing both feelings and functioning, based on Keyes' model of mental health (see Chap. 5).

Inspired by the work of Keyes, we see the potential in combining elements of theoretical framework from different times, cultures, disciplines and sciences to underpinning the today's art of nursing. Fig. 15.4 illustrates essential elements and areas of knowledge to make up a more complete mental health nursing practice.

In Fig. 15.4 the salutogenic orientation is of equal value as the pathogenic orientation. We do not claim this collection to be complete;

rather we challenge health professionals to put in elements to adapt the theoretical foundation to their actual setting. The main issue for us is to complement the pathogenic orientation with a salutogenic orientation to promote mental health for everybody and in the context of this chapter especially for adults with mental disorders. Further, we want to elaborate on one of the elements in Fig. 15.4, namely the salutogenic orientation as one important ingredient in the art of nursing.

15.4 Implementing Salutogenesis in Mental Health Nursing Practice

The time is ripe. Nurses have the knowledge to design evidence-based nursing aiming actively to promote patients' mental health, i.e. salutogenic mental health promotion. In the context of this book we want to give a more comprehensive elaboration of some features of the salutogenic-oriented mental health nursing, including some practical examples. We will continue with a presentation of some features of salutogenic-oriented mental health nursing as illustrated in the highlighted chart pie in Fig. 15.5.

First, we give attention to the holistic approach to the person in need of care, including the person's environment. The second feature is attention to the person's strength and resources and to the persons own experiences of coping and adaption in life. The third feature we want to elaborate on is saluseducation, a concept first used by Mjøsund [3, 8]. When the nurses teach and supervise persons about salutogenic mental health promotion, they conduct saluseducation. The fourth prerequisite for salutogenic-oriented mental health nursing is to get access to the patients' experiences, which demands an active involvement of the patient in planning and implementation of nursing. We also want to emphasize the need to bring the patient perspective into this knowledge production; the service user involvement in research. Nursing research should involve patients and other service users actively in studies.

Fig. 15.4 The knowledge base of a more complete mental health nursing practice

Fig. 15.5 Features of salutogenic-oriented mental health nursing – as part of a more complete mental health nursing practice

15.4.1 A Holistic Orientation to the Patient with Mental Illness

Salutogenic-oriented mental health nursing includes a view of human beings as whole persons (mind, body and spirit) who are inseparable from their environment. In a holistic approach, the nurse includes a broader perspective and considers the patient as part of a larger context. The history of a person is significant beyond the illness history, or the person's single symptom of illness [71]. The patient's socio-economic status and social network, such as family or next of kin, friends, and professional relationships, are significant sources in the nursing assessment. They might contribute to understand more of the individual's daily life, as well as being sources of GRRs and potential stressors in the patients' environment. A nurse trained in salutogenic-

oriented nursing will always expect to find some assets and resources in every human being, which make the patients able to cope with simple or difficult tasks that can promote a feeling of mastery, even in the most acute situation.

A salutogenic approach to nursing in mental health care services might balance the dominant emphasis on disorder symptoms and risks, as well as the common language that reinforces a focus on disorder. Acquiring new concepts from salutogenic theory will contribute to more comprehensive and holistic knowledge. One example is given by Langeland [72]; she claims using the word person and not patient consistently will help us be aware that it is the whole person we are focusing on and not just the diagnosis. Antonovsky [15] was occupied with a holistic view on human beings, focusing on the history of the person more than the symptoms, risk factors, and the organ dysfunction.

Different labels are used to describe approaches similar to salutogenic nursing; we might mention holistic nursing and integrative health care [73]. A review of the nurses' role in health promotion practice shows that their activities were guided by an individualistic and holistic approach to help patients and families make health decisions and support them in health promotion activities [74]. Salutogenic mental health promotion nursing is characterized by targeting issues of coping in everyday living. Nurses need to mind the here-and-now situation in the hospital while they give attention to the patients' environment and the context of daily life. Beside somatic treatment and psychotherapeutic interventions, treatment for patients with severe mental illness should also include psychosocial interventions [41].

See box 15.1 for an example of a clinical situation illustrating a holistic approach.

Box 15.1 Example of a Clinical Situation Focusing on a Holistic Approach

Nursing situation: Afternoon shift in an open inpatient unit. A man in his 50s is troubling with psychosis symptoms and do not want to take a shower.

Nurse: Can you remember taking a footbath from your childhood?

Patient: ... hmm, I remember taking footbath at my grandmother's place.

Nurse: I can arrange it for you now, your feet need some care. You deserve some wellness by hot water and a softening soap. I can cut your nails and apply some cream to your feet as well.

Assessment: This situation facilitated a dialog about the patient's situation at home and the troublesome relationship to his brother. He had not talked to him for 5 years. The story ended with a telephone call to his brother, assisted by the nurse.

achieve currently, and increasingly more in the future, creates hope and optimism. An explicit focus on salutogenic mental health nursing has the potential to strengthen a holistic and health-oriented nursing practice [57].

Influenced by Orem's conceptual model of nursing [65], the self-care agency of the patient here and now is assessed. The nurse need to take into consideration the ability of the patient to act independently, or by supervision, to satisfy self-care requisites of universal, developmental, or disorder-related conditions. Mental health nurses applying salutogenic mental health nursing emphasize the opportunities, resources and coping methods, as well as creating confidence for the patient that growth and development are possible. Building qualitatively good relations based on subject-to-subject relationships is an important foundation of the salutogenic approach, and nursing planning conducted in an atmosphere of partnership and equality with the patient is essential. A nurse-patient relationship should be established based on the recognition that each hold expertise in different fields. Where the patient is the expert in their life, with a range of experiences living with a mental disorder, and the trained nurse brings experiences from a large range of patient-meetings. Together these perspectives form the base for nursing interventions, and finding the right "fit" between the patient and the nurse.

A nursing planning process includes an assessment of the patient's resources and strengths. Significant knowledge is part of the patient's actual GRRs/SRRs, as well as the ability to use the resources. An explicit focus on coping and manageability based on utilization of GRRs/SRRs or getting access to new or extended GRRs/SRRs might bring important hope, energy and optimism. This is a counterpart to the more common focus on symptoms, risk assessment, and what is wrong.

See box 15.2 for an example of a clinical situation illustrating a strength- and resource-focused approach.

15.4.2 A Strength- and Resource-Focused Approach

Salutogenesis leads us to consider the human resources to strengthen health. Sharing positive expectations of what the patient can manage and

Box 15.2 Example of a Clinical Situation Focusing on a Strength- and Resource-Focused Approach

Nursing situation: A primary nurse approaches a patient with psychosis who

just started antipsychotic medicine. The nurse intends to become better acquainted with her patient's daily life and her family situation. They are together working with the nursing plan for the next 2 weeks.

Nurse: Now when you are on antipsychotic medication I know it is important to take a notice on your eating habits and your relationship to food.

Patient: I like to cook, and I like new recipes.

Nurse: Wow, your interest in cooking is positive, and a resource you possess. Do you know how to find out what the ingredients contain of calories, fat, sugar and proteins?

Patient: Yes, I think so, but I'm not sure. ...

Nurse: Should we go to a grocery shop together on Wednesday to discuss some shopping and possible ingredients to make healthy meals?

15.4.3 Saluseducation: Learning Processes in Mental Health Promotion

An important area of the nurse profession' is the education, supervision, and guidance intentions of nursing. Nurses should use their broad knowledge to educate patients and families in the realm of mental health promotion to increase coping and empowerment. Patient education is mandatory for specialized health care services in Norway [75]. One of the first traces of an educational function in nursing is found in Nightingale's writings [63], when she claimed that nurses' role was not only to care for the sick, but also to teach proper caring for those who care for the health of others. The purpose of the book "Notes on Nursing" was to write a guide to women on how to care for their family's health, not a manual on nursing [63]. Nightingale's messages translated into current mental health care practice of today: the role of nurses includes educational and training activities for the patients themselves, as well as for those who care for their relatives or family members.

Potential opportunities associated with coping in daily life after hospitalization is requested in

recovery and health promotion processes for persons with mental disorder [76]. A talk-therapy-group intervention based on Antonovsky's model of health for persons with mental disorders promoted SOC, coping, and mental health [76]. Talk-therapy based on salutogenesis treatment principles might be helpful in increasing coping among people with mental disorders [77]. Psychosocial interventions aimed at families are among the interventions supported by available evidence for individuals with severe mental disorders [41, 78, 79]. The health benefits rising from patient and family interventions aiming to increase health literacy, social and practical skills are relevant for mental health promoting nursing. Family intervention is a structured method for involving the patient and the patient's family members in treatment and rehabilitation, including family psychoeducation and skills training. Family interventions helps patients and families to cope through providing knowledge about the disorder and its symptoms, signs, crisis management, emotional support, and training in communication and problem solving in every-day life [41]. The broad and various elements in these interventions inspired from mental disorder knowledge, as well as a solution orientation to increase coping and mastery, make psychoeducation compatible with a salutogenic mental health promotion approach.

Psychoeducational interventions are associated with improved individual and social functioning and decreased relapse rates [41], therefore might educational activity be a GRR that enhances the patients' SOC. Many years ago, Landsverk and Kane [80] proposed that one of the processes through which psychoeducation works is in maintaining and enhancing an individual's SOC. The relationship between GRRs/SRRs and SOC seems to be a feedback loop: GRRs/SRRs provide experiences that lead to coping and enhanced SOC, and enables the patient to mobilize and use available resources [80].

Persons with severe mental health disorders express an appetite for learning [3], both about their disorder as well as their health in general. They requested *saluseducation* complementing a psychoeducational focus [3]. The *saluseducation* represents learning processes about health and health promotion, including knowledge and

skills relevant for everybody—to increase health and well-being. Saluseducation is not delineated to people with some illnesses, although saluseducation should be tailored to each person's individual situation. Saluseducation in groups might have a synergetic effect as persons with mental disorders emphasize the positive impact of spending time with others with the same mental disorder [3].

Empowerment represents a corner stone in the field of health promotion. Nurses have the responsibility to provide care to promote empowerment by the means of emancipation, self-efficacy, and self-management of patients with long-term mental illness [81]. Empowerment was rated as the most important intervention in health promotion in a study on attitudes towards aspects of health promotion interventions, and the patients rated alliance and educational support significantly higher than the staff did [82]. Empowerment might be reached by customizing learning processes, that takes into account the person's individual situation, and sharing knowledge in a health promoting manner.

The participants in a study by Mjøsund et al. [6], described the importance of being of significance to each other and being able to support or assist others were perceived as health promoting. Langeland, Gjengedal, and Vinje [83] investigated salutogenic talk-therapy groups; receiving constructive feedback from other participants in the group was significant in order to develop good relationships and a participatory competence, resulting in stronger identity, useful advices and tips as well as seeing things in new ways. Persons in the group built salutogenic capacity based on a sense of community and from the opportunities to discuss and reflect together with other group participants who were perceived as like-minded [83].

Clinical experiences from psychoeducational treatment groups involving persons with bipolar disorders [84] and family groups for persons with

schizophrenia spectrum disorders [85] have been an important inspiration to coin and introduce the term *saluseducation*. Persons with mental disorders and their families embrace knowledge they can apply immediately, without any assessment, diagnosing, or remedies, just to help themselves to live healthy lives with better mental health and well-being. Saluseducation together with psychoeducation provides opportunities to satisfy the knowledge appetite that persons with severe mental disorders have articulated [3].

See box 15.3 for an example of a clinical situation illustrating saluseducation.

Box 15.3 Example of a Clinical Situation Focusing on Saluseducation

Nursing situation: The nurse is holding an evening educational session for three patients with bipolar disorder and their next of kin at an inpatient ward.

Nurse: Some of my patients are curious about what to do for themselves to achieve better quality of life in their everyday activities. One of the things we all might be conscious about is our sleeping pattern. How long we sleep; when; sleeping hygiene like lower temperature in the sleeping room; open window for fresh air; what the bed should be reserved for; and regularities through the week and weekend. Now you might write down some questions coming up and we discuss some of them in a minute.

A father: I wonder about this afternoon nap. Could that be something that could help when you are a bit manic?

Nurse: I put the question at the board.

A young girl newly diagnose with bipolar disorder: When I visit my sister at weekends, we stay awake until early morning—that is probably not wise, or? Is it an explanation why? ...

15.4.4 Service User Involvement in Planning and Evaluation of Nursing

We argue that it is essential to involve the perspectives of patients and their relatives to secure a patient relevant focus in knowledge development and practice. Service user involvement is a prerequisite for salutogenic mental health nursing. Persons with mental disorders should be empowered and involved in mental health advocacy, policy, planning, legislation, service provision, monitoring, research, and evaluation according to WHO [86]. The message to nurses is that it should be mandatory and naturally for patients to be brought into the decision-making processes. Crucial in recovery processes and in promotion of health is that patients and their families should be given the opportunity to participate actively in partnership to promote shared decisions about care and treatments. A recent systematic review concludes that family interventions are effective for reducing relapse rates, duration of hospitalization, and psychotic symptoms, and for increasing functionality in patients with a first episode of psychosis [87].

In collaboration with the main person and their next of kin the intents for nursing interventions and activities beyond life-saving care, must be agreed on. The relationship between the patient and the nurse has been described, also by patients with serious mental disorders, as essential to achieve successful outcomes of health promotion programs [88]. However, a recent study by Terry and Coffey [89] showed that service user involvement did not form an important part of mental health nursing processes. Service user involvement was seldom mentioned by nurses themselves and nursing work was rather described as task-focused, with limited collaboration with the patients in areas like care planning [89].

Patient-centered care involves the patient in planning, delivering, and evaluation of the nursing care [90]. Patient-centeredness secures a focus on the needs of the user as opposed to the needs of the hospital or the nurse. Applying patient-centered care, the focus is on the patient's needs, values, and preferences. Only by actively taking the individual's specific situation as a

starting point can sustainable lifestyle changes that promote health occur.

See box 15.4 for an example of a clinical situation illustrating involvement of the patient in planning and evaluation of nursing.

Box 15.4 Example of a Clinical Situation Focusing on Involvement of the Patient in Planning and Evaluation of Nursing

Nursing situation: A primary nurse is walking in the park with a young patient Ann, who was admitted a few days prior with her first episode of psychosis. That afternoon, a meeting is scheduled to plan the treatment and care for the next week. The psychiatrist and the social worker will be there together with the nurse. Ann is invited; however, she is unsure if she will be there.

Nurse: I know you have experiences and information important for the planning of your treatment and care. For you, what is most important?

Ann: I don't know... I am not going to that meeting—and my cat has been alone since Thursday and I cannot give her food being here.

Nurse: I see... So the wellbeing of your cat is important? This is exactly what we need to know. I want to facilitate the information exchange between you and your team. We can do it in different ways. You and I can write down three important things for you, I bring it into the team and come back to you after the meeting. Alternatively, you come with me and I tell the others what you and I have been talking about. You have also another option. You might bring with you somebody you trust. And you can of course leave whenever you want.

Patient: I do not want my father to be there, neither my mother... I called my aunt Ellen yesterday...

Nurse: Your aunt Ellen, do you trust her? Maybe she is someone you can invite to be together with you when we discuss how to facilitate your treatment and care... and what we can do to take care of your cat.

15.4.5 Salutogenic Service User Involvement in Knowledge Production and Research

Experiential knowledge is an essential ingredient in the knowledge base of salutogenic-oriented mental health nursing. Lived experiences of receiving nursing and other treatments in health care are valuable for the development and improvement of the health care services. The field of mental health research has a long history of engagement with service users [91]. In research and knowledge production, the perspective of service users should be included, not only as informants but also in the research teams. Involvement takes place when research is carried out “with” or “by” patients rather than “to,” “about” or “for” them [92]. The involvement of service users in the research process should be conducted in the salutogenic way, as claimed by Mjøsund et al. [2]. An advisory team was included in the research team; the five members were different persons from the participants interviewed in the project. Either the research advisors were diagnosed with a severe mental disorder or had family members with a severe mental disorder. They articulated features of the collaboration process and labeled it a *salutogenic service user involvement* [2]. Six features of the collaboration process which encouraged and empowered the advisors to make significant contribution to the research process and the outcome were articulated; leadership, meeting structure, role clarification, being members of a team, a focus on possibilities, and being seen and treated as holistic individuals. These features were perceived to constitute a salutogenic and mental health promotive involvement [2].

Service user involvement is also essential in clinical quality improvement projects. Evidence-based knowledge always need to be adapted to a local setting and environment, then service users with experiences from the same context possess important knowledge to be included in improvement processes. Service user involvement also has the potential to enhance the research quality [4].

See box 15.5 for an example of a clinical situation illustrating the recruitment of a service user to a research project.

Box 15.5 Example of a Clinical Situation Focusing on Service User Involvement in Knowledge Production and Research

Nursing situation: Under a discharge conversation between the nurse and her primary patient, the nurse wants to recruit her patient to become a service user in a project they plan at the ward. The project aim is to implement a national guideline for the involvement of family or next of kin, when persons with severe mental disorder are admitted to the hospital.

Nurse: I know you want to actively use your experiences from receiving treatment from this ward over years. We need two persons with patient experience to join the project team, together with three persons being family members to someone being admitted to our section. Could you be interest?

Patient: hmm... What am I supposed to do? And where are the meetings? It is a long bus ride for me to come here. Who else is in the team?

Nurse: I have an information flyer here. Besides the persons I mentioned, three nurses from the section, including me and a nurse researcher are supposed to be in the team. How the involvement is designed will be developed in collaboration with the researcher. Is it ok if I contact you in a couple of days, then I probably know more about those practical things? ...

15.5 Act-Belong-Commit: A Framework for Exemplifying Salutogenesis in Mental Health Nursing

The use of body- and movement-related actions for the prevention and healing of illnesses has a long tradition. Apart from the various physical benefits, psychological changes have been postu-

lated [41]. The Act-Belong-Commit (ABC) mental health promotion campaign is assessed to be a comprehensive, population-wide program with a strong evidence base, demonstrating success in implementation and comprises universal principles of mental health and well-being [93]. The ABC campaign aims to target people in communities to engage in activities that enhanced their mental health. ABC might be used in different settings, both on a population level, in specified setting, and on an individual level [27].

The ABC-framework encourages individuals to engage in mentally healthy activities, and it appears to empower people with mental illness to take steps of their own to enhance their mental health [94]. The ABC-framework adapted in a health care and nursing context provides nurses and other health professionals with a practical framework for actually doing mental health promotion activities together with the patients. A population-based study of Irish older adults showed that the increase in the number of ABC-activities inversely predicted the onset of depression, anxiety, and cognitive impairment [95].

Mental health as well as physical and social health are related to lifestyle and cultivated by practice and what we do; *we become mentally healthy by engaging in mentally healthy activities* [27]. The ABC framework offers a structural approach to specific subpopulations in clinical settings. The ABC campaign is about keeping mentally healthy by keeping active, keeping up friendships and make connections with others, as well as engaging in activities that provide meaning and purpose in life [96].

- **Act:** Keep alert and engaged by keeping mentally, socially, spiritually, and physically active.
- **Belong:** Develop a strong sense of belonging by keeping up friendships, joining groups, and participating in community activities.
- **Commit:** Do things that provide meaning and purpose in life like taking up challenges, volunteering, learning new skills, and helping others.

Additionally, the ABC framework might be interpreted in three ways by which nurses and

other health professionals in charge can enhance the mental health of those in their care. It is to: **A**ctively involve (those in your care), **B**uild (their) skills, and **C**elebrate (their) achievements [97]. The situation in Box 15.6 illustrates how the ABC-principles might be turned into action. The nurse invites the patient to an activity (**A**ct) they are going to do together (**B**elong) in the future (**C**ommit), based on the patient's interest in nature (**C**ommit).

Box 15.6 Example of a Clinical Situation Focusing on ABC Activities

Nursing situation: Morning shift at a closed acute inpatient unit. The patient has been staying mostly in bed not talking for a couple of days.

Nurse: Good morning, my friend! I brought some flowers from my garden to you. I remember you were looking at the picture of some spring flowers in the newspaper yesterday.

Patient: ...Hmm.

Nurse: I'm on duty the day after tomorrow. Do you agree to come with me to the park by the main road to look at the trees over there – the leafs are in thousands of colors. ...

15.6 Conclusion

Mental health promotion is important to all of us, no matter if we are young or old and healthy or diseased. Salutogenic mental health promotion provides a resource and strength-based approach to promote mental health. Nurses in mental health care services are in an excellent position to include health promotion in their daily work with their continuous presence with the patients. In mental health care services, we claim that nurses need to provide a more complete mental health nursing to persons with mental disorders based in knowledge from both the paradigms of salutogenesis and pathogenesis. To emphasize the importance of salutogenesis in nursing care, we introduce the term salutogenic-

oriented mental health nursing practice. Features of the salutogenic-oriented mental health nursing are the holistic orientation, with emphasis on strengths and resources, facilitating learning processes in health promotion, salueducation, and the involvement of patients and next of kin in salutogenic nursing practices as well as in research.

Take-Home Messages

- Everybody could benefit from being involved in interventions aiming to promote mental health the salutogenic way.
- In mental health care services, the patients should receive a more complete nursing, based on knowledge from both the paradigms of salutogenesis and pathogenesis.
- Salutogenic-oriented mental health nursing is aiming to promote mental health as subjective well-being, understood in terms of the emotional state and psychological and social functioning of the patients.
- Salutogenic-oriented mental health nursing in mental health care services will be holistically oriented. Where patients are viewed as whole persons, body and mind, and part of a social environment and larger context.
- Salutogenic-oriented mental health nursing emphasizes the patients' capabilities, resources and ability to cope, and where personal growth and development are possible.
- The prerequisites for salutogenic-oriented mental health nursing is to put the patient at the center of shared decisions and evaluation of treatment and care.
- Salutogenic-oriented mental health nursing includes educational intervention to promote learning processes about mental health and how to promote, maintain, or protect good mental health.
- Salutogenic-oriented mental health nursing is evidence-based embedded in research including experiential knowledge and service user involvements.
- The Act-Belong-Commit framework for mental health promotion is an example of how to apply salutogenesis in mental health nursing practice.

Acknowledgement The authors would like to thank Vestre Viken Hospital Trust, Department of Mental Health Research and Development and University West, Department of Health Sciences for making it possible to write this chapter. Magnus Lien Mjøsund, thank you for reviewing the language and for assisting in fine-tuning of the figures.

References

1. The Norwegian Directorate of Health. National guideline about somatic health and lifestyle for persons with mental illness or additions. . In: Services MoHaC, editor. Oslo: The Norwegian Directorate of Health; 2018.
2. Mjøsund NH, Eriksson M, Haaland-Øverby M, Jensen SL, Kjus S, Norheim I, et al. Salutogenic service user involvement in nursing research: a case study. *J Adv Nurs*. 2018;74(9):2145–56. <https://doi.org/10.1111/jan.13708>.
3. Mjøsund NH, Eriksson M, Espnes GA, Vinje HF. Reorienting Norwegian mental healthcare services: listen to patients' learning appetite. *Health Promot Int*. 2018;34:541–51. <https://doi.org/10.1093/heapro/day012>.
4. Mjøsund NH, Eriksson M, Espnes GA, Haaland-Øverby M, Jensen SL, Norheim I, et al. Service user involvement enhanced the research quality in a study using interpretative phenomenological analysis: the power of multiple perspectives. *J Adv Nurs*. 2017;73(1):265–78. <https://doi.org/10.1111/jan.13093>.
5. Mjøsund NH. Positive mental health—from what to how. A study in the specialized mental healthcare service. Trondheim: Norwegian University of Science and Technology, Faculty of Medicine and Health Sciences, Department of Public Health and Nursing; 2017.
6. Mjøsund NH, Eriksson M, Norheim I, Keyes CLM, Espnes GA, Vinje HF. Mental health as perceived by persons with mental disorders—an interpretative phenomenological study. *Int J Ment Health Promot*. 2015;17(4):215–33. <https://doi.org/10.1080/14623730.2015.1039329>.
7. Mjøsund NH. Health promotion nursing in mental health care—patients' dream hospital. *Norwegian J Clin Nurs*. 2020. <https://doi.org/10.4220/Sykepleienf.2020.80478>.
8. Mjøsund NH. Helsefremming for personer med psykisk lidelse innlagt i sykehus [health promotion for persons with severe mental illness in hospital]. In: Haugan G, Rannestad T, editors. Helsefremming i spesialisthelsetjenesten [health promotion in specialized health care services]. Oslo: Cappelen Damm Akademisk; 2016. p. 236–54.
9. Mittelmark MB, Sagy S, Eriksson M, Bauer GF, Pelikan JM, Lindström B, et al. The handbook of Salutogenesis. Cham: Springer International Publishing AG; 2017.

10. Lindström B, Eriksson M. The Hitchhiker's guide to salutogenesis: salutogenic pathways to health promotion. Helsinki: Folkhälsan; 2010.
11. Eriksson M, Lindström B. A salutogenic interpretation of the Ottawa charter. *Health Promot Int*. 2008;23(2):190–9.
12. Eriksson M, Lindström B. Antonovsky's sense of coherence scale and its relation with quality of life: a systematic review. *J Epidemiol Community Health*. 2007;61(11):938–44.
13. Eriksson M, Lindström B. Antonovsky's sense of coherence scale and the relation with health: a systematic review. *J Epidemiol Community Health*. 2006;60(5):376–81. <https://doi.org/10.1136/jech.2005.041616>.
14. Eriksson M, Kerekes N, Brink P, Pennbrant S, Nunstedt H. The level of sense of coherence among Swedish nursing staff. *J Adv Nurs*. 2019;75(11):2766–72. <https://doi.org/10.1111/jan.14137>.
15. Antonovsky A. Unraveling the mystery of health: how people manage stress and stay well. San Francisco: Jossey-Bass; 1987.
16. Antonovsky A. Health, stress, and coping. San Francisco: Jossey-Bass; 1979.
17. Keyes CLM. Mental health as a complete state: how the Salutogenic perspective completes the picture. In: Bauer GF, Hämmig O, editors. Bridging occupational, organizational and public health: a transdisciplinary approach. London: Springer; 2014. p. 179–92.
18. Keyes CLM. Towards a mentally flourishing society: mental health promotion, not cure. *J Public Ment Health*. 2007;6(2):4–7. <https://doi.org/10.1108/17465729200700009>.
19. Keyes CLM, Haidt J. Flourishing: Positive psychology and the life well-lived. Washington, DC: American Psychological Association; 2003.
20. Keyes CLM. The mental health continuum: from languishing to flourishing in life. *J Health Soc Behav*. 2002;43(2):207–22.
21. Fugelli P, Ingstad B. Helse—slik folk ser det. *Tidsskrift for Den norske legeforening*. 2001;(Årg. 121, nr 30):3600–4.
22. Jormfeldt H, Svedberg P, Fridlund B, Arvidsson B. Perceptions of the concept of health among nurses working in mental health services: a phenomenographic study. *Int J Ment Health Nurs*. 2007;16(1):50–6. <https://doi.org/10.1111/j.1447-0349.2006.00444.x>.
23. Herrman H, Saxena S, Moodie R. Promoting mental health: concepts, emerging evidence, practice : a report of the World Health Organization, Department of Mental Health and Substance Abuse in collaboration with the Victorian Health Promotion Foundation and the University of Melbourne. Geneva: World Health Organization; 2005.
24. Antonovsky A. The life cycle, mental health and the sense of coherence. *Isr J Psychiatry Relat Sci*. 1985;22(4):273–80.
25. Mittelmark MB, Bull T. The salutogenic model of health in health promotion research. *Glob Health Promot*. 2013;20(2):30–8. <https://doi.org/10.1177/1757975913486684>.
26. Keyes CLM. Promoting and Protecting positive mental health: early and often throughout the lifespan. In: Keyes CLM, editor. Mental well-being: international contributions to the study of positive mental health. Dordrecht: Springer; 2013. p. 3–28.
27. Donovan RJ, Anwar-McHenry J. Act-belong-commit: lifestyle medicine for keeping mentally healthy. *Am J Lifestyle Med*. 2014;10(3):193–9. <https://doi.org/10.1177/1559827614536846>.
28. WHO. Mental health: strengthening our response. 2018. Accessed 18 Dec 2019.
29. Barry MM, Jenkins R. Implementing mental health promotion. Edinburgh: Churchill Livingstone; 2007.
30. Cattan M, Tilford S. Mental health promotion: a lifespan approach. Maidenhead: Open University Press, Mc Graw-Hill; 2006.
31. Eriksson M. The sense of coherence in the Salutogenic model of health. In: Mittelmark MB, Sagy S, Eriksson M, Bauer GF, Pelikan JM, Lindström B, et al., editors. The handbook of Salutogenesis. Cham: Springer International Publishing AG; 2017. p. 91–6.
32. Mittelmark MB, Bauer GF. The meanings of Salutogenesis. In: Mittelmark MB, Sagy S, Eriksson M, Bauer GF, Pelikan JM, Lindström B, et al., editors. The handbook of Salutogenesis. Cham: Springer International Publishing AG; 2017. p. 7–13.
33. Idan O, Eriksson M, Al-Yagon M. The Salutogenic model: the role of generalized resistance resources. In: Mittelmark MB, Sagy S, Eriksson M, Bauer GF, Pelikan JM, Lindström B, et al., editors. The handbook of Salutogenesis. Cham: Springer International Publishing AG; 2017. p. 57–70.
34. Mittelmark MB, Bull T, Daniel M, Urke H. Specific resistance resources in the Salutogenic model of health. In: Mittelmark MB, Sagy S, Eriksson M, Bauer GF, Pelikan JM, Lindström B, et al., editors. The handbook of Salutogenesis. Cham: Springer International Publishing AG; 2017. p. 71–6.
35. Bauer GF, Roy M, Bakibinga P, Contu P, Downe S, Eriksson M, et al. Future directions for the concept of salutogenesis: a position article. *Health Promot Int*. 2019;35:187. <https://doi.org/10.1093/heapro/daz057>.
36. Schramme T. On the autonomy of the concept of disease in psychiatry. *Front Psychol*. 2013;4:457. <https://doi.org/10.3389/fpsyg.2013.00457>.
37. Zachar P, Kendler KS. Psychiatric disorders: a conceptual taxonomy. *Am J Psychiatry*. 2007;164(4):557–65.
38. Hofmann B, Wilkinson S. Mange betegnelser for sykdom (Several terms for disease). *Tidsskrift for den norske legeforening*. 2016;136(12/13):1125–6. <https://doi.org/10.4045/tidsskr.16.0316>.
39. WHO. ICD-10: International statistical classification of diseases and related health problems. Geneva: World Health Organization; 2009.
40. American Psychiatric Association. Diagnostic and statistical manual of mental disorders: DSM-5. 5th ed. Washington, DC: American Psychiatric Association; 2013.

41. Gühne U, Weinmann S, Arnold K, Becker T, Riedel-Heller SG. S3 guideline on psychosocial therapies in severe mental illness: evidence and recommendations. *Eur Arch Psychiatry Clin Neurosci*. 2015;265(3):173–88. <https://doi.org/10.1007/s00406-014-0558-9>.
42. Wittchen HU, Jacobi F, Rehm J, Gustavsson A, Svensson M, Jönsson B, et al. The size and burden of mental disorders and other disorders of the brain in Europe 2010. *Eur Neuropsychopharmacol*. 2011;21(9):655–79. <https://doi.org/10.1016/j.euroneuro.2011.07.018>.
43. Wahlbeck K, Westman J, Nordentoft M, Gissler M, Laursen TM. Outcomes of Nordic mental health systems: life expectancy of patients with mental disorders. *Br J Psychiatry*. 2011;199(6):453–8. <https://doi.org/10.1192/bjp.bp.110.085100>.
44. Hjorthøj C, Stürup AE, McGrath JJ, Nordentoft M. Years of potential life lost and life expectancy in schizophrenia: a systematic review and meta-analysis. *Lancet Psychiatry*. 2017;4(4):295–301. [https://doi.org/10.1016/S2215-0366\(17\)30078-0](https://doi.org/10.1016/S2215-0366(17)30078-0).
45. Woodall J, Cross R, Kinsella K, Bunyan A-M. Using peer research processes to understand strategies to support those with severe, multiple and complex health needs. *Health Educ J*. 2019;78(2):176–88. <https://doi.org/10.1177/0017896918796044>.
46. Whitehead D, Irvine F. Ottawa 25+—‘All aboard the Dazzling Bandwagon’—developing personal skills: what remains for the future? *Health Promot Int*. 2011;26(suppl 2):ii245–i52. <https://doi.org/10.1093/heapro/dar072>.
47. Berg GV, Sarvimäki A. A holistic-existential approach to health promotion. *Scand J Caring Sci*. 2003;17(4):384–91. <https://doi.org/10.1046/j.0283-9318.2003.00240.x>.
48. WHO. In: Promotion FICoH, editor. Ottawa Charter for health promotion. Ottawa: WHO; 1986. p. 5.
49. International Health Promotion Hospitals and Health Services. The New Haven recommendations on partnering with patients, families and citizens to enhance performance and quality in health promoting hospitals and health services. *Clin Health Promot*. 2016;6(1):1–15.
50. Wise M, Nutbeam D. Enabling health systems transformation: what progress has been made in re-orienting health services? *Promot Educ*. 2007;45(Suppl 2):23–7.
51. de Leeuw E. Have the health services reoriented at all? *Health Promot Int*. 2009;24(2):105–7.
52. Catford J. Turn, turn, turn: time to reorient health services. *Health Promot Int*. 2014;29(1):1–4. <https://doi.org/10.1093/heapro/dat097>.
53. Latter S. The potential for health promotion in hospital nursing practice. In: Scriven A, Orme J, editors. *Health promotion: professional perspectives*. 2nd ed. New York: Palgrave; 2001.
54. Whitehead D. Exploring health promotion and health education in nursing. *Nurs Standard*. 2018;33(8). <https://doi.org/10.7748/ns.2018.e11220>.
55. Hudson K. Salutogenesis: the origin of health. *Nurs Manage*. 2013;44(11):12–3. <https://doi.org/10.1097/01.numa.0000436369.45139.81>.
56. Langius A, Björvell H. Salutogenic model and utilization of the KASAM form (sense of coherence) in nursing research—a methodological report. *Vård i Norden*. 1996;16(1):28–32. <https://doi.org/10.1177/010740839601600106>.
57. Sullivan GC. Evaluating Antonovsky’s Salutogenic model for its adaptability to nursing. *J Adv Nurs*. 1989;14(4):336–42.
58. Haugan G, Rannestad T. Helsefremmende helsearbeid -patogenese og salutogenese [health promotion in health care work—pathogenesis and salutogenesis]. In: Haugan G, Rannestad T, editors. *Helsefremming i spesialisthelsetjenesten [health promotion in specialized health care services]*. Oslo: Cappelen Damm Akademisk; 2016. p. 34–58.
59. Haugan G. Helsefremmende sykepleie i spesialist- og kommunehelsetjenesten [health promotion in nursing the specialized and municipality health care services]. In: Larsen TB, Gammersvik Å, editors. *Helsefremmende sykepleie—i teori og praksis [health promotion in nursing—in theory and practice]*. Oslo: Fagbokforlaget; 2018.
60. Haugan G. Helsefremming i kommunehelsetjenesten [Health promotion in the municipality health care services]. In: Ingstad K, Hedlund M, Moe A, editors. *Kunnskap i praksis—fellesskap og kommunal omsorg [Knowledge for practice—community and municipal care]*. In review: Universitetsforlaget 2020.
61. Becker CM, Rhynders P. It’s time to make the profession of health about health. *Scand J Public Health*. 2013;41(1):1–3. <https://doi.org/10.1177/1403494812467506>.
62. Antonovsky A. The salutogenic model as a theory to guide health promotion. *Health Promot Int*. 1996;11(1):11–8.
63. Nightingale F. *Notes on nursing: what is nursing and what is not*. New York: Dover; 1860.
64. Henderson V. *The nature of nursing: a definition and its implications for practice, research, and education*. Third printing, 1969 ed. New York: Macmillan; 1966.
65. Orem DE. *Nursing: concepts of practice*. 6th ed. St. Louis, MO: Mosby; 2001.
66. Grando VT. A self-care deficit nursing theory practice model for advanced practice psychiatric/mental health nursing. *SelfCare Depend Care Nurs*. 2005;13(1):4–8.
67. Lindström UÅ, Lindholm L, Zetterlund JE. Theory of Caritative caring. In: Alligood MR, editor. *Nursing theorists and their work*. 8th ed. Greenville, NC: Elsevier; 2014. p. 171–202.
68. Eriksson K. Hälsans idé (the idea of health). 2. Uppl. Ed. Vårdserie. Stockholm: Almqvist & Wiksell; 1984.
69. WHO. Ottawa charter for health promotion. *Can J Public Health*. 1986;77(6):425–30.

70. Espnes GA. Salutogenesis: the Book's editors discuss possible futures. In: Mittelmarm MB, Sagy S, Eriksson M, Bauer GF, Pelikan JM, Lindström B, et al., editors. *The handbook of Salutogenesis*. Cham: Springer International Publishing AG; 2016.
71. Vinje HF, Langeland E, Bull T. Aaron Antonovsky's development of Salutogenesis, 1979 to 1994. In: Mittelmarm MB, Sagy S, Eriksson M, Bauer GF, Pelikan JM, Lindström B, et al., editors. *The handbook of Salutogenesis*. Cham: Springer International Publishing AG; 2017.
72. Langeland E. Sense of coherence and life satisfaction in people suffering from mental health problems: an intervention study in talk-therapy groups with focus on salutogenesis [PhD]. The University of Bergen; 2007.
73. Frisch NC, Rabinowitsch D. What's in a definition? Holistic nursing, integrative health care, and integrative nursing: report of an integrated literature review. *J Holist Nurs*. 2019;37(3):260–72. <https://doi.org/10.1177/0898010119860685>.
74. Kempainen V, Tossavainen K, Turunen H. Nurses' roles in health promotion practice: an integrative review. *Health Promot Int*. 2013;28(4):490–501. <https://doi.org/10.1093/heapro/das034>.
75. Specialized Health Services Act. Act 1999-07-02-61. Act relating to specialized health services. 1999.
76. Langeland E, Wahl AK, Kristoffersen K, Hanestad BR. Promoting coping: salutogenesis among people with mental health problems. *Issues Ment Health Nurs*. 2007;28(3):275–95. <https://doi.org/10.1080/01612840601172627>.
77. Langeland E, Riise T, Hanestad BR, Nortvedt MW, Kristoffersen K, Wahl AK. The effect of salutogenic treatment principles on coping with mental health problems a randomised controlled trial. *Patient Educ Couns*. 2006;62(2):212–9. <https://doi.org/10.1016/j.pcc.2005.07.004>.
78. Pharoah F, Mari JJ, Rathbone J, Wong W. Family intervention for schizophrenia. *Cochrane Libr*. 2010. <https://doi.org/10.1002/14651858.CD000088.pub3>.
79. Dixon LB, Dickerson F, Bellack AS, Bennett M, Dickinson D, Goldberg RW, et al. The 2009 schizophrenia PORT psychosocial treatment recommendations and summary statements. *Schizophr Bull*. 2009;36(1):48–70. <https://doi.org/10.1093/schbul/sbp115>.
80. Landsverk SS, Kane CF. Antonovsky's sense of coherence: theoretical basis of psychoeducation in schizophrenia. *Issues Ment Health Nurs*. 1998;19(5):419–31.
81. Jönsson PD, Nunstedt H, Berglund IJ, Ahlström BH, Hedelin B, Skärsäter I, et al. Problematisation of perspectives on health promotion and empowerment in mental health nursing—within the research network “MeHNuRse” and the Horatio conference, 2012. *Int J Qual Stud Health Well Being*. 2014;9(22945):6. <https://doi.org/10.3402/qhw.v9.22945>.
82. Svedberg P, Hansson L, Svensson B. The attitudes of patients and staff towards aspects of health promotion interventions in mental health services in Sweden. *Health Promot Int*. 2009;24(3):269–76. <https://doi.org/10.1093/heapro/dap019>.
83. Langeland E, Gjengedal E, Vinje HF. Building salutogenic capacity: a year of experience from a salutogenic talk-therapy group. *Int J Ment Health Promot*. 2016;18(5):247–62. <https://doi.org/10.1080/14623730.2016.1230070>.
84. Skjelstad DV, Norheim I, Reiersen GK, Mjøsund NH. Psykoedukasjon i gruppe for personer med bipolar lidelse. En presentasjon av kursmodellen, deltagerens tilfredshet, og implementeringserfaringer. (Group psychoeducation for people with bipolar disorders). *Tidsskrift for Norsk psykologforening (J Norwegian Psychol Assoc)*. 2015;52(12):1041–50. <http://www.psykologtidsskriftet.no/pdf/2015/1041-1050.pdf>.
85. Norheim I, Mjøsund NH. Psykoedukative flerfamiliegrupper for unge med psykose: familien som ressurs i bedringsprosessen. *Ergoterapeuten*. 2010;(Årg. 53, nr. 6):22–7.
86. WHO. Mental health action plan 2013–2020. Geneva: World Health Organization; 2013.
87. Camacho-Gomez M, Castellvi P. Effectiveness of family intervention for preventing relapse in first-episode psychosis until 24 months of follow-up: a systematic review with meta-analysis of randomized controlled trials. *Schizophr Bull*. 2019;46:98. <https://doi.org/10.1093/schbul/sbz038>.
88. Shiner B, Whitley R, Van Citters AD, Pratt SI, Bartels SJ. Learning what matters for patients: qualitative evaluation of a health promotion program for those with serious mental illness. *Health Promot Int*. 2008;23(3):275–82. <https://doi.org/10.1093/heapro/dan018>.
89. Terry J, Coffey M. Too busy to talk: examining service user involvement in nursing work. *Issues Ment Health Nurs*. 2019;40:1–9. <https://doi.org/10.1080/01612840.2019.1635667>.
90. McCormack B, McCance T. Person-centred practice in nursing and health care: theory and practice. 2nd ed. Chichester: Wiley; 2017.
91. Wallcraft J, Schrank B, Amering M. Handbook of service user involvement in mental health research. 1st ed. Chichester: Wiley-Blackwell; 2009.
92. National Institute for Health Research. Good practice guidance for involving people with experience of mental health problems in research. London: Mental Health Research Network; 2013. Accessed 14 Aug 2013.
93. Koushed V, Nielsen L, Meilstrup C, Donovan RJ. From rhetoric to action: adapting the act-belong-commit mental health promotion Programme to a Danish context. *Int J Ment Health Promot*. 2015;17(1):22–33. <https://doi.org/10.1080/14623730.2014.995449>.
94. Donovan RJ, Jalleh G, Robinson K, Lin C. Impact of a population-wide mental health promotion

- campaign on people with a diagnosed mental illness or recent mental health problem. *Aust N Z J Public Health*. 2016;40(3):274–5. <https://doi.org/10.1111/1753-6405.12514>.
95. Santini ZI, Koyanagi A, Tyrovolas S, Haro JM, Donovan RJ, Nielsen L, et al. The protective properties of act-belong-commit indicators against incident depression, anxiety, and cognitive impairment among older Irish adults: findings from a prospective community-based study. *Exp Gerontol*. 2017;91:79–87. <https://doi.org/10.1016/j.exger.2017.02.074>.
96. Act-Belong-Commit Campaign. The act-belong-commit. Guide to keeping mentally healthy. Curtin University Perth, Australia. 2013. Accessed 30 Sept 2019.
97. Donovan RJ, James R, Jalleh G, Sidebottom C. Implementing mental health promotion: the act-belong-commit mentally healthy WA campaign in Western Australia. *Int J Ment Health Promot*. 2006;8(1):33–42. <https://doi.org/10.1080/14623730.2006.9721899>.

Open Access This chapter is licensed under the terms of the Creative Commons Attribution 4.0 International License (<http://creativecommons.org/licenses/by/4.0/>), which permits use, sharing, adaptation, distribution and reproduction in any medium or format, as long as you give appropriate credit to the original author(s) and the source, provide a link to the Creative Commons license and indicate if changes were made.

The images or other third party material in this chapter are included in the chapter's Creative Commons license, unless indicated otherwise in a credit line to the material. If material is not included in the chapter's Creative Commons license and your intended use is not permitted by statutory regulation or exceeds the permitted use, you will need to obtain permission directly from the copyright holder.