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Jürgen M. Pelikan

The Challenge of Integrating Salutogenesis into Health Care

Health care, or more correctly the "disease care system" (Antonovsky, 1996, p. 12), is a very specific and challenging area for applying salutogenesis. And for health or disease care, implementation of salutogenesis is quite a challenge as well.

What is the essence of these challenges of integrating these two health related fields? The health care sector still primarily follows a pathogenic paradigm. It intends to professionally manage illness by trying to cure, what is defined as a disease, or, if this is not possible, at least to offer care for chronic patients and palliative care. But the contribution of health care to public health, or health promotion more specifically, is still marginal. Reorientation of health services, as demanded by the Ottawa Charter (World Health Organization 1986), has not happened to a remarkable degree yet (De Leeuw, 2009; Wise & Nutbeam, 2007). There still is quite an unrealized potential in health care to be more preventive of disease and more protective and promotive of positive health.

Salutogenesis as defined by Antonovsky has been developed as a paradigm in opposition to this "pathogenic orientation which suffuses all western medical thinking" (Antonovsky, 1996, p. 13). Therefore, in principle applying salutogenesis to health care means to restrict the leading pathogenic orientation in health care practice (research and policy) and complement or change it by a salutogenic orientation in every day practice and research. This can only partly be established as an add-on of new routines, and partly has to be done as an add-in to ongoing practices, by re-orienting core processes of health care.

As health care and its quality discourse is dominated more and more by the dictum of evidence based practice, if salutogenesis is to be acceptable in health care, it has to demonstrate its evidence-based character. But salutogenesis, a partly normative concept, also has quite an unrealized potential for being more evidence based. Antonovsky himself stated, "in short, at the present time, the appeal of the full salutogenic model for those engaged in health promotion cannot be on the grounds of powerfully demonstrated efficacy in producing significant health-related change outcomes" (ibid., 16). The relevant question, therefore, is how far has this changed since Antonovsky wrote this statement?

Salutogenesis—the newer and more focused concept—has been introduced by Antonovsky into health promotion, an older and broader concept, field, and movement. As Antonovsky saw it, "the basic flaw of the field (of health promotion) is that it has no theory". And he proposed "the salutogenic orientation ... as providing a direction and focus to this field". But he also believed, "the salutogenic model is useful for all fields of health care. In its very spirit, however, it is particularly appropriate to health promotion."(ibid., 18) Thus, health promotion in health care definitely has the blessings of Antonovsky. Therefore, we have to clarify how the salutogenic orientation or model and its related construct of sense of coherence can be integrated into health care, directly or via (re-)orienting health promotion in health care indirectly.

What Does Salutogenesis Specifically Mean for Health Care?

In health care, the salutogenesis paradigm can be used in principle for two purposes: either to guide health promotion interventions in healthcare practice, or to (re)orient health

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M.B. Mittelmark et al. (eds.), *The Handbook of Salutogenesis*, DOI 10.1007/978-3-319-04600-6_25

care research. For this, the salutogenesis paradigm offers specific concepts, assumptions, and instruments. Three quite different conceptual forms can be distinguished: a salutogenic orientation, a salutogenic model, and the construct of the SOC and a "methodologically respectable way to operationalize it" (ibid., 13). These three forms first have to be specified in more detail, to be applied later to the field of health care. For that, health care has to be understood as a complex of a strongly interrelated professional practice, with clinical research and supporting policy. Therefore, applying salutogenesis in health care successfully cannot just be done by introducing salutogenesis in health care practice, but must also include salutogenic clinical research, and change in underlying health care policy.

The first and most broad form of salutogenesis, a *salutogenic orientation* is described by three assumptions:

- "That the *human system (as all living systems) is inherently flawed*, subject to unavoidable entropic processes and unavoidable final death" (ibid.: 13). Therefore, the necessity of adaptation or coping with accompanying tension that may result in stress is universal and not the exemption.
- "A *continuum model*, which sees each of us, at a given point in time, somewhere along a healthy/dis-ease continuum" (ibid.: 14). Therefore, a dichotomization of people into healthy and sick is arbitrary and not adequate.
- The concept of *salutary factors* (or health promoting factors): "factors which are negentropic, actively promote health, rather than just being low on risk factors." (Antonovsky, 1996, p. 14). Therefore, risk *and* salutary factors have to be attended.

From these three assumptions follows implications for health promotion:

"A *salutogenic orientation*, as the basis for health promotion, directs both research and action efforts

- To encompass all persons, wherever they are on the continuum
- And to focus on *salutary factors*." (ibid.: 14)
- This "must relate to *all aspects of the person*" (ibid.: 14) instead of "to focus on a particular diagnostic category" as in curative medicine or also in preventive medicine, i.e., to include primary prevention or secondary prevention! (ibid.: 14)

Applying these assumptions and implications to health care practice would mean that:

1. Since a salutogenic orientation encompasses all persons independent of their position on the healthy/disease continuum, health care should not only just care for the health of its patients, but also has to take responsibility for the health of its staff and the health of citizens in the catchment area as well (while dichotomous classification of persons into those who have some specific disease or not, seems to be still unavoidable for doing curative medicine on patients!).
2. In relation to these three groups of stakeholders, not only their risk factors have to be dealt with or fought by health care, but also possible salutary factors have to be enhanced as well in curative, preventive, protective and promotive practice.
3. A holistic approach, including physical, mental, and social respectively ill and healthy aspects of a person, has to be taken into account in dealing with all people affected by health care.

In principle, to apply these demands on health care sounds plausible and rational. But to realize (1), a policy change of the mandate of health care is necessary, to realize (2), the traditional diagnostic and therapeutic repertoire of health care has to be widened, and to realize (3), a radical change of clinical outlook is implied. The last is especially difficult, since part of the spectacular medical success rests on focusing on a narrow bio-medical model.

The second form of salutogenesis is Antonovsky's specific and rather complex *salutogenic model* (described in Chap. 7 of Antonovsky, 1979). Within this model the concept of *generalized resistance resources* (GRRs) is introduced as "a property of a person, a collective or a situation which, as evidence or logic has indicated, facilitated successful coping with the inherent stressors of human existence" (Antonovsky, 1996, p. 15). Major psychosocial, genetic, and constitutional GRRs are specified within this model. But this model has not much been taken up by Antonovsky or other authors in later publications (Mittelmark & Bull, 2013)!

When using this *salutogenic model* in health care, the generalized resistance resources specified in detail in the model would have to be more adequately taken into account in health care practice and research. This makes much sense for health care and affords a more holistic and complex outlook and a widening of diagnostic and therapeutic methods applied.

The third most focused form of salutogenesis, the specific *construct of sense of coherence* (SOC), which has been introduced as a central factor in the salutogenic model of health, is defined as:

> "a generalized orientation toward the world which perceives it, on a continuum, as comprehensible, manageable and meaningful. The strength of one's SOC, I proposed, was a significant factor in facilitating the movement toward health." This construct answers "what do all these GRRs have in common, why do they seem to work. What united them, it seemed to me, was

> that they all fostered repeated life experiences which, to put it at its simplest, helped one to see the world as 'making sense', cognitively, instrumentally and emotionally." (Antonovsky, 1996, p. 15)

One way to interpret this is that Antonovsky introduces the SOC rather as a moderator or mediator of other determinants of health than as a specific further determinant of health. Compared to other familiar concepts from the *coping literature*, "it is the particular combination of the cognitive, behavioral and motivational which is unique" and, furthermore, "the SOC is not a culture-bound construct." "What matters is that one has had the life experiences which lead to a strong SOC; this in turn allows one to 'reach out', in any given situation, and apply the resources appropriate to that stressor." "The strength of one's SOC (as a dependent variable) is shaped by three kinds of life experiences: consistency, underload-overload balance, and participation in socially valued decision-making. The extent of such experiences is molded by one's position in the social structure and by one's culture . . ." (ibid.: 15). Two *instruments/tools* have been offered to measure the SOC, a longer 29-item SOC scale and a shorter 13-item version, but both are *not* suitable to measure the three specific sub-dimensions of the SOC (Antonovsky, 1993).

How can the SOC be introduced into health care? Being ill and becoming a patient in professional health care often is a rather threatening life experience for people and being a health care professional is a rather demanding kind of job. Therefore, using the SOC concept for making health care structure and culture as far as possible consistent, underload–overload balanced and participatory for patients, staff, and visitors would be an adequate and welcome application to make health care systems more salutogenic, generally. This is possible, since "social institutions in all but the most chaotic historical situations can be modified to some degree" (Antonovsky, 1996, p. 15). It even could be more feasible, effective and efficient to develop salutogenic 'standards' (Dalton & Mccartney, 2011) and make institutional contexts more salutogenic, than to try to directly enhance the SOC of large numbers of patients, staff, and citizens. Thus, patients and staff could be supported by health care organizations to experience their roles and tasks as comprehensible, manageable, and meaningful. That at least, would reduce avoidable stress, most important for people with a low SOC. More specifically, the SOC of patients or staff could be measured or screened, and their level of SOC be taken into account in treating or deploying them, even if this seems to be a rather far reached and also problematic stigmatizing kind of application. Even if Antonovsky assumed that one's SOC cannot be radically transformed, he left it open that the SOC could "be shaped and manipulated so that it in turn can push people towards health" (Antonovsky, 1996, p. 15). Therefore, improving one's SOC or at least one's health literacy could become an explicit goal of chronic disease management.

In summary, salutogenic thinking has good potential to be applied to health care in relation to health promoting interventions for the health of patients, staff, and citizens, and in supporting health promoting structures and cultures of health care institutions for better everyday practice and policy.

Contributions of the Chapters of the Section

Salutogenic Architecture in HealthCare Settings

Jan A. Golembieski

In his salutogenic model of health, Aaron Antonovsky has included in his column on Major Psychosocial Generalized Resistance Resources "material" resources as number one. But what is meant by material resources? Antonovsky enumerates: "money, physical strength, shelter, clothing, adequate food, and the like" (1987, p. 107). Health care as well needs some kind of shelter and health and nursing care architecture has taken up, to a different degree, Antonovsky's ideas on salutogenesis. Most directly used in architecture and design have been the three subdimensions of the sense of coherence. Salutogenic spatial and socioenvironmental structures can support comprehensibility, meaningfulness, and manageability of life, which is steady coping with challenges, by intentionally offering specific and general resistance resources by these structures. The chapter offers evidence that aesthetic design in health care, especially hospitals, can improve health outcomes for patients. By its influence on the brain and the body, architecture can directly influence health. Thus, the international Academy of Design and Health has contributed to improvement in the quality of new health care buildings around the world. There seems to accumulate evidence that neurotransmitters react to environmental stimuli, and therefore react to design. Furthermore, has the concept of aesthetic impact on health outcomes been scientifically been tested with very promising results. In addition, detailed and concrete examples are given how architecture can support manageability, comprehensibility, and meaningfulness for patients. Even if by now the term salutogenesis may be overused and imprecisely used in architecture it can be said that salutogenesis has achieved the status of a respected and encouraged design goal. On this can be built in the future to bring salutogenic principles by newly developed more systematic methods into health care design. But to support

this also with decision makers, far more research on salutogenesis, including its effects on efficiency of health care and better integration of salutogenesis into architectural theory and teaching will be necessary.

The Application of Salutogenesis in Hospitals

Christina Dietscher, Ulrike Winter, and Jürgen M. Pelikan

Hospitals, in developed countries the center of curative health care in practice, research, and education, still have a dominantly pathogenic orientation. Therefore, salutogenic principles definitely have to offer to quality improvement of cure and care in hospitals. But salutogenesis also is a considerable challenge to be implemented in hospitals, and hospitals are challenging for health and salutogenesis promoters. The chapter first demonstrates how salutogenesis, if understood as a specific dimension of hospital quality, could considerably contribute to better health gain for patients and hospital staff. Second, drawing on a comprehensive literature search, it is highlighted which aspects of salutogenesis in relation to hospitals already are covered in descriptive and intervention research focusing on patients (and family members), staff, and the hospital as an organization. Topics included are: concepts of salutogenesis referred to, the SOC in relation to physical symptoms; the SOC in relation to mental symptoms, quality of life, and patient satisfaction; the SOC adjustment to disease, self-management, and adherence to treatment; the SOC and social outcomes; the SOC and positive health; the SOC in relation to gender, age, and socioeconomic status; the SOC in relation to patients' family members; salutogenesis in general and the Salutogenic Model; salutogenesis and impacts of the hospital setting on patients; using the SOC as a diagnostic tool; adapting treatment schemes; supporting self-care and self-management; supporting caring relatives; improving the impact of hospital functioning on salutogenesis; salutogenesis for different health care professions; and implications for occupational health in hospitals.

An overview on the application of salutogenesis in Health Promoting Hospitals, one of the WHO-initiated setting-oriented health promotion networks, also is provided.

Needs for further research are outlined focusing mainly on the specific role of the sense of coherence as predictor, mediator, or moderator, by better conceptual clarity and more complex research designs, on the interlink between the SOC and other aspects of health than subjective and mental health, on the impact of hospital functioning and organizational interventions on salutogenesis or the SOC specifically, and on the applicability of the SOC as measurement to assess the outcome of health promotion interventions in hospitals.

The Application of Salutogenesis in Mental HealthCare Settings

Eva Langeland and Hege Forbech Vinje

This chapter also deals with salutogenesis for another specific and growing group of patients. Antonovsky's core concept of sense of coherence has been shown to be more closely related to mental health than to physical health. Thus, the application of salutogenesis on patients in mental healthcare settings is rather obvious. This firstly holds for the principal paradigmatic understanding of mental health problems or disorders as a challenge for patients which depends on the individual's personal way of experiencing it, by their health care professionals. Second, it can result in specific forms of salutogenic therapy, for example, talk therapy groups that aim to support positive salutogenic identity building as a specific resistance resource and to improve sense of coherence of patients by specific offers of social support. This approach emphasizes to increase participants awareness of and confidence in their potential internal and external resources and possibilities to cope successfully and effectively manage tension. Third, as in all health care the material and social setting itself should be designed by salutogenic principles as empowering by being comprehensible, meaningful, and manageable. This especially is important for more sensitive and vulnerable chronic mental patients who also experience longer stay in mental health care organizations.

Some experimental evidence for the feasibility and effectiveness of this kind of therapy is offered, while systematic intervention research on this application of salutogenesis in mental health care is still rather limited.

The Application of Salutogenesis in the Training of Health Professionals

Hege Forbech Vinje, Liv Hanson Ausland, and Eva Langeland

How work is done in health care organizations as professional bureaucracies or expert organization is considerably

determined by the professional outlook of health care workers and this again by their professional education. Therefore, if salutogenesis should be used in health care to a remarkable degree, this will depend on its integration already in all stages of professional education. Furthermore, since many health care institutions do not only offer cure, care, and education to their patients, but also play an important role in the education to their staff, salutogenic training of professionals for salutogenic treatment of patients is at stake within many organizations of the health care system. This chapter offers, based on research and teaching, principles and examples for salutogenic designs of training programs for health professionals at different levels, from bachelor to continuous education. Principles highlighted include salutogenesis not only as a body of knowledge, but also as a continuous learning process, as a way of working and of being. An aim for this kind of education is that the student manages herself in a salutogenic way, by developing the capability called 'self-tuning,' a process of habitual self-sensitivity, and reflection and mobilizing of resources to maintain and improve one's own health. Thus, the precondition to expect from a health professional to assist patient's in good self-care is that the health professional has acquired a 'salutogenic capacity' first for herself. And this has to be the outcome of salutogenic professional training that uses salutogenic principles on the educational process itself and by that supports personal development and experiential learning of the participants. How that can be done in practice the chapter demonstrates by three more detailed examples, teaching salutogenesis to health promotion generalists, teaching group leaders of salutogenic talk-therapy groups, students practicing participatory methods the salutogenic way.

The Application of Salutogenesis in Vocational Rehabilitation Settings

Monica Lillefjell, Ruca Maass, and Camilla Ihlebaek

Rehabilitation services are more closely and directly linked to maintaining and regaining positive health lost by illness and by pathogenic side effects of health care than provision of cure or care. There even exists some professional understanding that rehabilitation should start with the beginning of treatment and be integrated into treatment processes and not just follow after discharge of patients. But even the WHO definition of rehabilitation has a pathogenic bias by focusing on disabilities of people or on disabled people and not addressing their abilities explicitly, even if rehabilitation is defined as enabling "for optimal physical, sensory, intellectual, psychological and social functioning". Therefore, salutogenesis still has to offer something and has an added value to rehabilitation as a supporting intervention for recovery processes. In addition, rehabilitation itself can be seen as a process where participants have to deal with considerable challenges at biological, psychological, and social levels and their coping will be influenced by the existing level of the participants' sense of coherence.

Within the wider field of rehabilitation this chapter has a specific focus on vocational work-oriented rehabilitation which is a combination of medical, psychological, social, and occupational activities with the goal of enabling timely return to work after sickness absence. For that the chapter highlights how salutogenesis can be related to the design and implementation of vocational rehabilitative services. A summary of descriptive and intervention research is given on the impact of the SOC as a moderator on processes and outcomes of rehabilitation programs and on the influence of these programs on the development of the SOC, which shows that there is empirical evidence for both kind of effects. Recommendations for further research with more complex longitudinal designs are given, but the greatest challenge in the future will be not only just strengthening *individuals* by salutogenic rehabilitation programs, but also assessing and influencing problematic challenges of work place *environments* by these programs.

The Application of Salutogenesis to Aged and Highly Aged Persons: Residential Care and Community—Dwelling Settings

Viktoria Quehenberger and Karl Krajic

This chapter focuses on a specifically vulnerable group of aged and highly aged patients, who have long and rather comprehensive contacts with health care institutions of long-term care, either in residential aged care or in community dwelling. Therefore, it is well accepted in the literature that a salutogenic orientation and health promotion measures could contribute to the quality of life, well-being, and health of this group. Furthermore, a good sense of coherence can be considered as a positive resource for coping with the physical, mental, and social challenges and transitions related to aging.

But the state of *descriptive* research on salutogenesis focusing not only on residents but also somewhat less so on community dwellers is still scarce and has mostly been conducted in few countries. Different subjective and objective health outcome measures have been used on the two

groups, but scarcely more complex theoretical assumptions have been researched. There is research on determining, mediating, or moderating effects of the SOC on health outcomes, but results are still diverse. There also exist studies exploring stability of sense of coherence in older age, but due to their cross-sectional design their results have to be interpreted with caution.

Concerning *intervention* research only "very few studies have specifically applied salutogenic principles to promote positive health among older people." Mostly studied were consequences of physical activity interventions which had positive effects on sense of coherence and well-being indicators. One study also showed an increase of sense of coherence by psychotherapy.

In light of this scarce research situation, the authors make recommendations for further research in this relevant and growing area of health care which should make use of better clarified theoretical assumptions and hypotheses with more complex comparative cross-sectional or even better longitudinal designs and more elaborated measures for GRRs and SOC. Furthermore, it has to be dealt with one of the major limitations of existing research, where aged and highly aged with cognitive impairment have mostly been excluded from the research.

The Application of Salutogenesis in Health Development in Youth with Chronic Conditions

Isabelle Aujoulat, Laurence Mustin, François Martin, Julie Pélicand, and James Robinson

This chapter uses the concept of salutogenesis for a very specific but also growing group of patients, adolescents or young adults with a serious chronic condition. This situation creates a specific challenge not only for the young people in question, but also for their therapists and treating health care institutions as well. While all adolescents have to cope with the challenge "to establish a continuous and valuable sense of self" in a phase of transition, adolescents with a chronic condition have to do this with a particular handicap. They have to integrate their chronic condition into their identity and to build up specific resources for adequate self-care. From their parents and health care professionals they need comprehensive support. The chapter reviews literature on how Antonovsky's sense of coherence construct has been demonstrated to relate to important medical and psychosocial outcomes like adherence and self-care, general health behaviors, perceived health, quality of life and general well-being, and sense of self and identity. Based on the existing evidence, more systematic implementation of salutogenesis into practice for young people in health care is advocated for.

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