Chapter 2
A Salutogenic Approach to Tackling Health Inequalities

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2.1 Introduction

In the 1960s the anthropologist Colin M. Turnbull wrote two books that raised much debate – "The Forest People" and "The Mountain People" (Turnbull 1961; Turnbull 1972). The books were about two African tribes, the first living in its original habitat in the forest, thriving and deeply rooted in its culture, rituals and mastery of life in spite of the hard living conditions of the jungle. The other tribe had been driven from its original habitat by "the modern development", to face hunger, disease, and a struggle for survival. The mountain people finally lost their pride and culture, this first created internal conflicts and manslaughter, at the end, a state of mental collapse and total apathy. The debate in the 1960s was about the right to write about the death of a culture in such a depressing way. This still was a time of hope and dreams of a prosperous, independent future in Africa and the ending of colonisation.

Looking back 40 years later at Africa, with the endless series of civil wars, the exploitation and misuse of resources and on top of it the HIV/AIDS catastrophe, one could argue that the picture Turnbull painted was closer to real life than he had ever expected. As an anthropologist he used his stories to draw painful parallels from the developing world and phenomena within Western cultures to highlight universal trends. The state of the mountain people is similar to what has been called the "concentration camp disease" where people just give up because they have lost their meaning in life. On the other hand, we have the stories of people who in spite of these hardships never lose their motivation and out of this hopeless situation create a meaning. This meaning enables them, not only to survive, but to carry on with

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life in full mental and spiritual well-being. This phenomenon came under scientific study about 25 years ago and created the framework for salutogenic research (Antonovsky 1979, 1987). We have just completed a systematic study of salutogenesis and found that there is a strong correlation to mental well-being and quality of life in populations and individuals who have developed a strong sense of coherence – the key mechanism in the salutogenic model. The model has been tested in at least 32 different countries in 33 languages and it was found that the model works in all these diverse cultures (Eriksson and Lindström 2005, 2006).

2.2 Background

The focus of this book is the concepts and models conducive to positive health. One would wish there were universal features and models within health promotion that could be helpful on a global scale and support the general development of mankind. Besides the description of so called "positive concepts" of health our aim here is to look for universal concepts and solutions. At the same time postulating that many of the post-modern trends that upset mental stability are global features that either directly or indirectly influence all countries of the world. It is also clear that Western cultures have a strong focus on the individual and the protection of the rights of the individual as stated in the United Nations (UN) Declaration of Human Rights, as compared to cultures where the collective efforts are considered more important than the individual. From the perspective of health promotion this can make a huge difference, as the emphasis on either the collective or the individual creates different prerequisites for health, including mental health.

2.3 The Present: From Modernity to Post-Modernity

The literature of post-modern or late-modern society is today abundant but diverse (Bauman 1989; Giddens 1990, 1991). While ancient society was based on mythical and religious beliefs, the Modernity from the Enlightenment period until present day holds the rational and logical perspective of science as the ultimate tool for the explanation of reality, in its smallest detail. While public health develops as a construct of modernity. Post-modernity again deals with the deconstruction of society in all respects; everything from the society's central institutions to central values. The world is seen as ahistorical and deinstitutionalised, driven by the subjective ethics of the individual. More moderate theories say that we are in a transition period called the late-modern period (Giddens 1990, 1991). Post-modernists claim man is living in a vacuum without any view of where he is coming from or going to (Bauman 1989). The rationality and logic of science is questioned because it has proved to be unable to explain all aspects of reality. As a consequence, man turns to other models or explanations and forces (like the market or new age ideology) which compete for command of the mind. The post-modern person is alienated from the local community. Instead abstract systems, symbolic values (such

as market and media) disturb this relationship and expert systems have become the power to turn to when religion lost its footing (Giddens 1990, 1991). This means that a person, instead of trusting their own judgement or their support network of family and friends, turns to expert advice which takes command of issues that ordinarily could be solved by the person himself. Thus post-modern man can be described as a vulnerable, rather confused, disillusioned person that tries to find his own way in a chaotic and fragmented existence without coherence. At the same time, Western societies carry the ideal of the individual at centre, his freedom of choice and autonomy stands above the needs of the collective (Bourdieu 1993). More activities are available per time unit than ever before, helping to create a ever complicated set of circumstances under which people are expected to build their competence for health and life.

2.4 The Issue of Health Once Again

Much of the critique around various descriptions of health has been that the concepts stem from the orientation of disease where health and disease are placed on the same axis but are diametrically opposed to each other. This would indicate that the same mechanisms would operate in the creation of disease as in the creation of health but in different directions. This is partly true but there are also other options. If one considers in more detail the elimination of a pathogenic condition (a disease) in an organism often means that the specific condition is taken out of the system with little or no consideration of the effect on the health equilibrium. The traditional World Health Organization (WHO) declaration of health from 1948 suffers from the same deficit where "health" is seen as an absolute level which is only achieved when disease is taken out of the system (WHO 1946). Health is therefore defined by the absence of disease. If we instead create a model where there are three different dimensions: disease and its opposite "contra-disease", health and its opposite "contra-health" and quality of life and its opposite "contra-quality of life", one may assume that the state of health, contra-disease and quality of life are situated in the same pole. However, one can combine the positions in any way (partly depending on the definitions of health, disease and quality of life). For example, a person with a high quality of life may have a low degree of health and a high degree of disease, or a person who perceives she has a high degree of well-being in spite of suffering from a disease and limitations of functions. In the same way there are people with a low quality of life who can have a high degree of health and no disease. In fact, one can imagine any combination of the three dimensions.

The WHO only included a fourth dimension, spiritual well-being, to the physical, social and mental dimensions in the 1980s (Mahler 1987). Today, health is seen as an asset for everyday life and not an end product. This is stated in the Ottawa Charter (WHO 1986) on health promotion where health is seen as the process that can lead to the fulfilment of people's life goals. "*Health promotion is the process which enables people to gain control over their health determinants in order to improve their health and thereby be able to live an active and productive life*" (WHO 1986).

One can see this process as three phases, the first recognises the background (the determinants), while the second sets an objective (to lead an active productive life). The third phase is the activity (the enabling process) where the determinants are used to reach the objective in a dialectic relationship between people, the setting and the enablers. While at the heart there is the active, participating human being.

In general there is much more knowledge and information on what causes disease and the treatment of these conditions (the pathogenic orientation) than on what causes and then maintains and develops good health (the salutogenic orientation). Only recently there has been concrete theoretical and empirical constructions oriented towards the salutogenic framework, the most well known is Antonovsky's framework (Antonovsky 1979, 1987).

2.5 An Interdisciplinary Framework to Health?

It is possible that the concept of mental health needs to be examined from other, and joint perspectives, rather than simply as a health science in order to be fully understood (Klein 1990). One approach may be the theory and practice of interdisciplinarity which has evolved as a theoretical framework over the last century.

Klein describes interdisciplinary work as being a way of:

- Answering complex questions
- Addressing broad issues
- Exploring disciplinary and professional relations
- Solving problems that are beyond one discipline
- Achieving unity of knowledge on a limited or grand scale

The understanding of any societal mental health discourse is a complex question involving history, macro-politics, socio-economic development culture and traditions of both individual nations and continents as a whole. Interdisciplinary research has a history over the past century involving most social sciences and especially educational sciences supported by many scientists, intellectuals and organisations (such as the Organisation for Economic Co-operation and Development (OECD), and United Nations Educational, Scientific and Cultural Organization (UNESCO)). It has been particularly apparent in the critical movements such as structuralism and deconstruction (Lévi-Strauss, Foucault, Kuhn among others). The strength of the interdisciplinarity is the integrative approach.

The health sciences have had such a strong disease orientation that it becomes difficult to look beyond this approach. A typical example of this problem is the use of the quality of life concept in health and medical research. After its introduction, there was a brief period of a broader understanding of the quality of life concept but it is now dominated by the so called "health-related quality of life" research, actually evaluating the effect of medical interventions on people's quality of life. This is good and relevant research but it should rather be called disease-oriented quality of life research, as the concept of positive health has been lost.

2.6 Welfare as a Prerequisite for Well-Being

Welfare within the industrialised world after World War II was increasing at a stable rate until the early 1970s. Material living conditions also improved for the majority of the population. In sociology, the negative effects of economic growth raised the question of other welfare measurements besides the gross national product (GNP) per capita.

Although concepts such as the standard and level of living have been used since the early twentieth century, they were not defined before the UN published a report on "International Definition and Measurement of Standards and Levels of Living" (1954). This report stated that the best way of defining the level of living in a population is to quantify clearly defined aspects, or parts of the individuals' life situation, correlating to the objectives of the UN Charter. The UN attempted to find a composite measurement to describe components of different life spheres of the population. The components chosen represented the aims of the different UN organisations. Standard of living was later defined as:

> The level of satisfaction of needs of the population assured by the flow of goods and services enjoyed in a unit of time or…the extent to which the overall needs of the population are satisfied.
>
> (Johansson 1970)

The first studies using these measures were conducted in the UK and West Germany, where indicators such as the extent of ownership of TV, cars, telephones etc., were used. The UN has later been criticised for the over-emphasis on the importance of consumer goods.

The OECD in Europe developed a system of measuring social development. This activity has later been combined with similar activities within the UN. The economic recession in the mid-1970s increased the interest to develop compound social indicators. These were developed through a process of, firstly by developing a list of social concerns, secondly by developing indicators and thirdly by field testing. The first list of indicators was published in 1973 (List of Social Concerns Common to Most OECD Countries) and was revised in 1982 (The OECD list of Social Indicators 2009). The latter includes the following indicators:

1. General Context Indicators
2. Self-sufficiency Indicators
3. Equity Indicators
4. Health Indicators
5. Social Cohesion Indicators

In the Nordic countries, Sweden was the first to apply studies on the level of living. The emphasis was on finding and describing the living conditions of the general population with special focus on low income groups. The perspectives used were distribution of resources and individual control, and the level of living standards were defined as:

> The individuals' disposition of monetary resources, goods, knowledge, physical, mental energy, social relations, security …, which enable the individuals to control and consciously influence the conditions. The components that were considered relevant in the late 1960s

> in Sweden were: health, nutritional patterns, housing, conditions of upbringing, family relations, education, employment, working conditions, economic resources, political resources, leisure time and recreation.
>
> (Johansson 1970)

The Swedish study influenced subsequent Norwegian, Finnish and Danish national studies of living conditions. Completed in 1975, the Finnish study was a comparative Nordic study, which also explicitly uses the term of quality of life. The study, entitled "Having, Loving and Being", defined welfare as: *"a state where people are able to satisfy their central needs"* (Allardt et al. 1980).

Allardt et al. (1980) described two dimensions of welfare: the material and the non-material. The level of living is set by the degree of satisfaction of material needs while well-being is defined by satisfaction of non-material needs. The dimensions of standard of living and quality of life are given in Table 2.1.

The level of living (having) is defined in material (objective) resources and the individuals' satisfaction with these (subjective). Quality of life (loving and being) is defined by the individuals as satisfaction of non-material needs in relation to other people, society and nature.

In the United States a somewhat similar tradition developed. The focus of interest was perceived satisfaction in respect to different spheres of life. Campbell defined quality of life as a subjective measure describing how people experience their lives (Campbell et al. 1976). Objective conditions of life were considered less important. The central concepts in Campbell's research were satisfaction and happiness.

A combination of both subjective and objective data was introduced by Andrews and Whitney developing measures of "perceived life quality" (Andrews and Whitney 1976). Life is divided into different roles (working life, housing, family, companionship) and different values (success, beauty, freedom, happiness) and a combination of the above. Statistical analyses resulted in 12 factors important to the individual's quality of life: the individual's experience of: (1) self-concept, (2) family life, (3) economy, (4) life enjoyment, (5) housing, (6) family activities, (7) disposition

Table 2.1 "Welfare" having – loving – being

	Objective indicators (needs)	Subjective indicators (wants)
Emphasis on the material and impersonal	Level of living: objective measures of material or impersonal resources	Dissatisfaction: subjective feelings of satisfaction – dissatisfaction as regards the material living conditions
Emphasis on the non-material and social	Quality of life: objective measures as regards people's relation to 1. Other people 2. Society 3. Nature	Happiness: subjective feelings of happiness

Allardt et al. (1980)

of personal time, (8) leisure time activities, (9) government, (10) local access to goods and human services, (11) health, (12) occupation. Originally 100 different spheres were analysed and about 5,000 people were interviewed.

In the Nordic countries, as a critique to Allardt and Johansson the Swedish sociologist, Swedner, developed a model he calls "Take-Have-Give" where both qualitative and quantitative methods are used to describe the social reality of people (Swedner 1983). According to this model, "health" is something the individual achieves and maintains (have). In order to be able to accomplish this, resources are actively taken from the immediate surroundings (take). Quality of life is defined within the activity arena (give) (love, self-respect, appreciation, self-realization). This model considers individuals as social beings. A good quality of life is achieved when social networks are functioning and psychological needs are fulfilled.

To achieve a high standard of living the individual has to be satisfied within the following life areas: physical capability, ability of social contact, knowledge, working skills, influence on physical environment, power, ability to reach set objectives. These resources can be used to reach certain objectives both on the individual level (happiness or joy) and on a group level (companionship, security, solidarity). These life objectives are considered to be the qualities of life, which describe the existence of an individual or a group (Swedner 1983). Do people who live in welfare states perceive they have a high state of mental health or well-being? This question is difficult to answer.

Subjective well-being has such a strong cultural component. However, one can see that the welfare states have provided dimensions that improve physical and social well-being and Denmark and Sweden, with well established welfare states, rank repeatedly among the first in the world in relation to happiness or subjective well-being. Whilst it is impossible to talk about direct causal relationships, there is evidence that interventions at community level improve and increase mental well-being. The strongest evidence comes from the WHO healthy city project where a controlled intervention in a city proved that providing multilevel resources increased levels of satisfaction and optimism of the population (de Leeuw 2003).

In social science, quality of life has been included in the concept of "welfare" to describe mainly non-material human needs or perceived well-being or "loving" and "being". Human activities or "doing" and "giving" in the sense of self-realisation and self-respect and respect for others have later been introduced as quality of life concepts.

There are some additional theoretical aspects that can be useful in this context of finding coherence for systems. They have served as inspiration but are not further explored in this chapter. These are the concept of "habitus" by Bourdieu (Bourdieu 1993) (which relates to a common collective consciousness), and Bronfenbrenner's ecological development model (combining micro, meso and macro systems) (Bronfenbrenner 1979).

Some concepts have recently come to the fore within health promotion research. These are the concepts of social capital and empowerment. Social capital identifies the social resources of a person in terms of human relationships. Social capital and networks have always been difficult to study and quantify empirically. While Diderichsen and Whitehead make a distinction between vertical and horizontal social capital (Whitehead and Diderichsen 2001).

Horizontal social capital relates to people's intimate and immediate human relationships. In terms of health, horizontal social capital seems to promote mental and psychological well-being and the individual's self-esteem. Vertical social capital refers to how the individual relates to horizontal social capital and other social levels such as neighbourhood, local community, city, region and nation. This notion is similar to the concept "connectedness" used in resilience research in school age children. Connectedness seems to promote both physical and mental health and school success. The instrument is developed by the United Nations Children's Fund (UNICEF) and has been tested in over 60 different countries with similar positive results (Blum,[1] personal communication, 2001).

The next concept central to the health promotion process itself is the principle and theory of empowerment (Freire 1970; Rappaport 1987). Freire used empowerment as a way of learning, focusing on populations that have difficulties in acquiring learning in ordinary institutions. He was working on the reduction on inequity by learning and mobilising the uneducated. He was for a period expelled from his country, Brazil, because his government became afraid of the revolutionary component in his learning philosophy regarding redistribution of power. Empowerment is about giving people control and mastery over their own lives; similar to the enabling process in health promotion. It is about the development of abilities and coping skills and endowing people with the ability to enable and to work for active critical consciousness-raising. It is also a democratic concept looking at the structure of power and a process of professional activity and a relinquishment of the professional power.

2.7 Can Learning Be Conducive to Mental Well-Being?

Like empowerment, the learning process itself can promote well-being, if it is carried out according to the principles of health promotion. Learning, in its broadest context, is the interaction between a person (the actor) and the world (the structure) and mediated by activity or other people producing coherent knowledge. The way people are treated by others in learning situations will affect their well-being. The science of learning is complex not easily transferable due to its strong associations with culture and traditions. For instance, the way mothers in Bali socialise their children by completely neglecting the child if it expresses its demands through aggression or crying would, in a Western context, be an indication of severe neglect. Another comparison between countries with students with a similar high level of mathematical skills, found different teaching methods were used. In the Netherlands, teachers tended to provide students with models for solutions, while in Japan the teachers first let the students try to find their own solutions. In both countries, students have excellent mathematical skills, yet it doesn't necessarily follow that the

[1]Professor Robert Blum, Department of Population, Family and Reproductive Health, Johns Hopkins Bloomberg School of Public Health.

Dutch students would become even better if the teachers adopted Japanese learning strategies. This is because the teachers' learning methods are indicative of the countries' individual cultures (Stigler,[2] personal communication, 2003).

Learning can be superficial, particularly where people are taught simply to memorise, without real understanding. Some have better skills (genetic or acquired) to memorise than others, however people tend to forget details after only a short period of time. Therefore, if teaching is to be effective, sustainable and correlated to mental well-being, superficial learning corresponding mainly to cognitive intelligence is not recommended as a learning principle for health promotion.

The effects of learning are also related to the micro-culture of the student, i.e. social class and belonging. If these facts are not considered, learning can be ineffective and exclusive. Most schools are constructed around a non-differentiated learning model where the ones who come from a family background and social class with "school intelligence" are favoured as these children already have a "learning culture" to do well in schools. Schools could therefore unwillingly increase social and health differences (Rutter 1980; Nutbeam 1993; Nilsson 2003). Another approach is so-called in-depth-comprehension or deep-learning. In deep-learning there is a focus on connecting what is taught to the background and culture of the ones who are learning. In addition, deep-learning not only favours cognitive intelligence but also responds to the other qualities of intelligence (Gardner 1991).

Effective learning is related to the contents, the methods of delivery, the setting (context) including the emotional climate, the quality and relationship between learner and teacher and finally to the form of evaluation or outcome. Today it is considered that it is more effective to let students construct their own knowledge and integrate that into their value-system rather than being fed with ready-made facts. "Evidence based learning" exists in several forms and has to be adapted according to several of the factors mentioned previously creating wholeness, coherence and mental well-being (Lindström and Nafstad 2003). Effective learning is stimulated via a variation of methods, which should be shaped and defined through constant evaluation.

2.8 Positive Concepts of Mental Health Within Social Psychology

More than 40 years ago Marie Jahoda presented a report "Current concepts of positive mental health" (Jahoda 1958). The task was given by the US Joint Commission on Mental Illness and Health to find an evidence base to support decisions regarding the reconstruction of mental health services in the US. The report concluded that the most common definition of mental health is the absence of mental illness. Another approach was to use normality, either as a statistical normal phenomena or as a

[2]Professor Stephen M. Stigler, Department of Statistics, University of Chicago.

normative idea of how the human being should function. Jahoda voiced scepticism about both approaches, pointing out the danger of cultural definitions of normality such as those prevalent in Nazi Germany (she herself had been forced to flee Austria because of the German Anschluss).

Jahoda's report included six topics (all of which individually, or in combinations, were thought to serve as criteria for mental health):

1. Attitudes of the individual towards herself
2. The development of self-esteem
3. The degree of the integration of personality
4. The level of individual autonomy
5. The sense of reality
6. The ability of the individual to adapt to the environment

She then postulated what conditions characterise a state of good mental health. There is a need for: a positive self-concept; an ability to be active and to develop individual talents; to be an integrated person; to be able to take individual decisions and actions without isolating oneself from other people; to have an adequate perception of reality and good emphatic skills; and finally to be able to create deep and lasting relationships to other persons (at least one to a person of the opposite sex). However, there has been little use of Jahoda's work in practice.

The Norwegian psychologist, Siri Naess, created the concept "inner quality of life" equal to mental well-being (Naess 1974, 1987, 1979). The criteria for a good inner quality of life are based on a normative value system structured around a theoretical analysis. According to Naess the inner quality of life increases when the individual:

1. Is active
2. Has good interpersonal relations
3. Feels self-esteem
4. Has a basic mood of joy

These concepts are defined as:

1. *Active in the sense of*: being interested and engaged in something outside yourself (hobby, work, politics, religion, art) which you experience as meaningful, having an appetite for life.
2. *Self-esteem in the sense of*: knowing yourself, feeling good as a human being, being aware of your skills, feeling useful, satisfied with your achievements, morally valuable and reaching set standards.
3. *Good interpersonal relations in the sense of*: having a close, mutual and warm relationship to at least one human being, having an active satisfying sexual relation, finding friendship and loyalty and a feeling of participation and belonging (to friends, neighbours, working companions, friends).
4. *Joyful state of mood in the sense of*: having rich intense feelings of beauty, feeling close to nature, open and receptive, secure, harmonious, the absence of worry, anxiety and restlessness, a state of joy and compassion, finding life rich and rewarding, the absence of emptiness, depression, pain and discomfort.

The values are not ranked hierarchically but are all considered equally important (Naess 1974). Naess (1979) argues that society as a whole benefits more from allocating resources to children than to other population groups. This is because children have a long life ahead of them and they will be able to influence their own children who again will have children. On a population basis, the middle-aged group probably has the greatest resources available while the elderly have least resources at their disposal. Hypothetically, a society could use this argument and allocate such resources to increase the quality of life in the elderly. This intervention enhances the quality of life of the elderly but they can never reach the level of the general population. Sooner or later, the quality of life of other groups would decrease. Schools and day-care services for children would suffer, which would have a negative effect on the general quality of life of the population in the long term. Therefore investment in children would provide the best value for money.

Obviously, Naess' value system can create strong individuals or groups that have little solidarity towards society as a whole. A further development of Naess' ideas towards a system considering both the inner quality of life concept and external factors has been made by Kajandi: *"In spite of all, man is a social being, living in a social context in groups and societies out of the simple reason that this promotes survival and welfare. A central component of the quality of life is thus the sense of contribution to the best of the group and society by individual labour"* (Kajandi 1981). As a consequence Kajandi added the external conditions of life where work, the personal economy and housing are the central concepts. Thus, three spheres of life are included in Kajandi's model: external conditions (work, economy, housing), interpersonal relations (intimate relationships, friendships, family relations), inner psychological conditions (activity, self-concept, basic mood). The inner psychological conditions include: activity, self-image and basic state of mood (joy). These concepts are almost identical to the model that Naess created and are therefore not repeated here.

To conclude, quality of life in psychology was initially used to set objectives for people's mental well-being, based on theoretical analyses and normative value systems. Quality of life is described in life spheres where the psychological dimension represents the personal sphere (Naess et al. 1979), the interpersonal sphere describes social relationships and the external sphere socioeconomic conditions (Kajandi 1981). The model was developed further by Lindström for public health and health promotion including four life spheres as seen in Table 2.2 below (Lindström 1994).

This quality of life model is a development of Naess' and Kajandi's models. Naess (1974) described a value based model for "inner quality of life" using mental and social components. This was related to a socioeconomic context by Kajandi (1981). Here the model is expanded into four life spheres: The global, external, interpersonal and personal sphere. These components can be adapted universally to any human context: every person has a physical, mental and spiritual dimension representing the personal sphere. This is experienced in a context of social relationships and support, i.e. the interpersonal sphere which again has a socioeconomic context, i.e. the external sphere.

Finally there is a macro level including a society and its culture in a geophysical context, i.e. the global level. This general quality of life model needs to be further operationalised for the individual or population approached. This model has

Table 2.2 A general quality of life model, life spheres and dimensions

Spheres	Dimensions (objective/ subjective)	Examples
Global: ecological, societal and political resources	1. Macro environment 2. Culture 3. Human rights 4. Welfare policies	Physical environment, respect for human rights, equity, resource allocation
External: social and economical resources	1. Work 2. Income 3. Housing	Education, employment, economy, standard of housing. Satisfaction with these conditions
Interpersonal: resources in social relationships and support	1. Family structure and function 2. Intimate friends 3. Extended social support	Size of family, friends, intimate relationships, support from neighbours and society. Satisfaction with above
Personal: personal resources	1. Physical 2. Mental 3. Spiritual	Growth, activity, self-esteem and basic mood, meaning of life

Lindström (1994)

recently been suggested as an instrument in the evaluation of the effectiveness of health promotion (Raphael 2002).

Another model of similar value is the Canadian model: "Being, belonging and becoming", which has a clearer process orientation (Raphael 2002). Quality of life is here considered as a dynamic, holistic and complex multidimensional phenomenon, based on a deep and equal respect for the individual and his/her own expression, which is the outcome of interactions between the person and the environmental context. Hence the quality of life developed by the Canadian Centre for Health Promotion is:

> … the degree to which the person enjoys the important possibilities of his or her life. (Rootman et al. 1992)

2.9 Methodological Problems in Assessment of Happiness, Well-Being and Quality of Life

There are many problems involved in the assessment of quality of life, subjective well-being or happiness. According to Heal and Sigelman cited by Shalock there are four major ways in which methods for assessing well-being can differ (Shalock 1990). Firstly, measures can be objective and/or subjective. Secondly, they can be absolute or relative, i.e. either directly index people's quality of life or compare it to an optimum standard. Thirdly, quality of life can be reported directly by the subjects of study or assessed by someone else (by an informant or a proxy such as a relative, friend or by the investigator). This method is used when it is difficult to get a direct reply from the subject because of developmental reasons or communication difficulties.

Finally, the measure can be generated by the investigator or by the subject of study. Measures can be objective, i.e. focus on conditions (such as standard of housing, income and level of education) or subjective, i.e. focus on perceived satisfaction with life in general or with specific conditions of life. Objective measures can be evaluated externally while the subjective ones need an internal evaluation.

Historically, in quality of life studies, only objective measures have tended to be used but today subjective or combined subjective-objective measurements are more common. There are several difficulties involved in the interpretation of the subjective dimensions and the perceived quality of life. Individuals, cultures and nations have different levels of aspirations and also different ways of expressing satisfaction. This means that people can express higher or lower levels of satisfaction with exactly the same objective circumstances. Generally people with low incomes and low education or older people tend to idealize their conditions, i.e. express more socially desirable levels of subjective well-being (de Maio 1984). However the effect on self-reported assessments has been shown to be small (Atkinson 1982; Crowne and Marlowe 1964), and the use of anonymous questionnaires also reduces this tendency (Naess 1987).

On the individual level there are people who tend to agree or disagree with whatever is being asked (so-called yay- or naysayers). It has been shown that subjective well-being measured as an overall life satisfaction on a national level is fairly consistent. Nineteen countries participating in a survey on life satisfaction, repeated over 10 years, kept almost the same rank order over time. Denmark and Sweden held the top positions (Ingelhart and Rabier 1985), while Japan and Greece ranked the lowest. No developing countries participated in the survey.

On the individual level, longitudinal studies have shown that subjective global well-being (or basic mood) is fairly consistent in spite of intermediate negative or positive life events. Life events have a time-limited effect on the subjective wellbeing (Veenhofen 1991). People tend to readjust to base levels quicker when positive, rather than negative life events have occurred (Lazarus and Lannier 1979).

In studies where several subjective measurements are used they have been found to correlate more strongly to each other than to the actual objective indices of quality of life (Mastekaasa et al. 1988). Children create a special problem in the assessment of subjective well-being, because their responses tend to be more inconsistent over time (Shalock 1990).

The measure of quality of life can be generated by the investigator or by the subjects of investigation (Campbell et al. 1976). Campbell used this latter method asking the population what areas of life were perceived as most important using about 100 alternatives and through various statistical methods ended up with 12 areas later used in interviews. Flanagan (1982) asked people of different socioeconomic and age groups about critical life incidences that had enhanced or worsened their life and arrived at five general dimensions of quality of life: physical and material well-being; relations with other people; social activities; personal development and recreation. Naess (1979) used a philosophical argumentation approach to design an instrument for the measurement of "inner quality of life". This method represents a value-based method which was also used by Kajandi (1981) but in combination with external life conditions.

A major decision in the study of quality of life is the choice between the individual approach and the population approach. Most quality of life research is based on individuals where their personal needs, functions and preferences are assessed. One of the limitations of the individual approaches is the difficulty of generalizing the findings to a whole population group. The population approach defines general characteristics of a group of people, and assesses the quality of life conditions that are important for this population. Thereby a standard or norm for such a population is formed. Each quality of life indicator is standardized on the basis of what is good or bad for the population (Shalock 1990). In this process a base value has to be set for each variable.

In welfare studies such base values or "floor values" have mainly been used to register problems, e.g., the number of children living in poverty (Allardt et al. 1980). The quality of life approach focuses on people's resources, thus the quality of life base values measure how well people are doing. It is possible to use life-enhancing mechanisms such as in the salutogenic approach, i.e. defining general resistance resources of a population (Antonovsky 1979, 1987).

Thus, if the objective is to establish an acceptable base level for the population, it is less interesting to describe groups that do extremely well or extremely badly. According to Mastekaasa the increase of a certain variable, such as an increase in economic resources, is not always positively correlated to quality of life (Mastekaasa et al. 1988; Naess et al. 1979). Up to a certain level the increase can have a positive influence on quality of life but this is not always constant. Sometimes a further increase can have no, or even a negative effect on quality of life (Ventegodt 1995).

It is possible to weight variables depending on their presumed importance. However, weights have seldom been used since it is difficult to find objective weighting criteria. One way to reduce this difficulty is to avoid variables that represent people's preferences and concentrate instead on variables that give people choices (Ringen 1988).

Finally, people in different societies live under different conditions and have different requirements. Therefore, the base values vary depending on what society is studied. Nevertheless, the framework as such can be applied and in those societies with strong similarities, common base values can be used to form a quality of life standard.

2.10 The Concept of Resilience

The concept of resilience stems from psychology and is a way of explaining how people can manage life and live well in spite of adverse situations. As a scientific concept it was first developed for children and young people and has later been expanded into adulthood. The evidence base on the concept of resilience includes over 40 years of data from a longitudinal study (Werner and Smith 1982, 2001). In addition, Rutter has presented a historical development of the concept of resilience which has been defined in a number of ways (Rutter 1985). At first it was a question of demonstrating how negative life events produced developmental delays and psychiatric disorders as was demonstrated in the mental health movements of the early

twentieth century. Resilience was put on the agenda again after World War II through Bowlby's studies of separations and negative factors leading to psychiatric disorders (Bowlby 1979). Later the focus was on the conceptualization of various types of life events and their effects and how personal losses or environmental threats lead to psychiatric problems. According to Rutter, the risk potential of different life experiences varied in their impact on cognitive and behavioral development.

More recently, it was demonstrated there were many children who, in spite of these extreme conditions in their environment, still managed to develop normally. It was not only a question of the quality and quantity of life events but of factors related to the individual and the context. This lead to the concept of invulnerable children or Gidden's concept of "steel dolls", i.e. children who were constitutionally so tough they could endure almost any external pressure (Dencik 1989). However, it was later demonstrated that resistance is relative depending on both the environment and the constitution. Further, resistance is not a stable quality but varies over time and circumstances. It also became evident that there were factors that could ameliorate the impact of life events which again leads to the search for protective factors, which modify or alter a person's response to an environmental hazard.

The longest prospective study related to resiliency is a study from Kauai in Hawaii where consecutive generations have been studied over four decades (Werner and Smith 1982; Werner and Smith 2001). Fonagy et al. (1994) however, argue in a paper on the theory and practice of resilience that the first and most important key to resilience in childhood is based on the reflective dialogue, the person being confirmed, seen and respected for what she is by a trusted person or a significant other. The literature on resilience is difficult to review as it has so many entry points. In principle this research is looking for factors that enable people to develop normally in spite of adverse life conditions. Firstly, factors related to the individual (genetics, age, developmental stage, gender, constitution, life experience and life history). Secondly, the context (social support, social class, culture, setting). Thirdly, the quantity and quality of life events (desirability, controllability, magnitude, clusters, time-duration and long-term effects).

In adolescence there has been a focus on how well the social arenas of the young, the family, the social and geographical context, cultural and historical context, the learning systems, finally, the work place or daily activity, are connected. Evidence shows that the connectedness of these arenas has a major impact on resilience, life success and well-being (Resnick et al. 1997). This has been studied in different ethnic, social and cultural groups in over 60 countries. The conditions and skills to manage are different over different time periods and cultural contexts. This fact is important in the application of resilience theory. If it is a question of developing competence and a new repertoire to reach one's life goals, it is important to understand that competence applied yesterday perhaps is not functional today because the conditions have changed. This underlines the fact that in the post-modern times characterized by its rapid changes and turbulence, many of the traditional structures and functions of societal institutions, such as family and school, have

been undermined and are no longer of such importance. In addition, values and structures have become less coherent as new players such as the market systems, media and new information technology move into the arena. We thus have to look for more flexible models of resilience. This is why the salutogenic model (see later in this chapter) has such strength – it does not deal with development, specific structures or protective factors.

Both Rutter (1980) and Antonovsky (1979, 1987) emphasize at the relativity of concepts; protective factors in one context can be risk factors in another and vice versa. One can easily be seduced by the idea of the resilient child or person but in a humanistic perspective it is first of all important to consider the issue of ethics, equity, sustainable human settlements and ecology rather than admiring the survival of the strongest and most competitive individuals. It would be much more important to develop societies and life conditions where individual resilience is not fundamental but rather focus on creation of settings where we all have the opportunity to live well. However, the knowledge gained from research on resilience can be used for this purpose.

2.11 The Salutogenic Framework

More than 20 years ago Aaron Antonovsky introduced his salutogenic theory, "sense of coherence", as a global orientation to view the world and the individual environment as comprehensible, manageable and meaningful, claiming that the way a person views life has a positive influence on their health (Antonovsky 1979, 1987). The sense of coherence (SOC) theory explains why people in stressful situations stay well and even are able to improve their health. The SOC theory, integrating a stressor-resource concept, could be useful to help people manage all kinds of daily stressors and major life events and still remain healthy. Fundamental to the salutogenic theory is that health is viewed as part of the health ease/disease continuum. Health is here seen as a movement or a process, where people are always in some respects healthy and independent of existing distress and diseases. The paradigm shift from the pathogenic focus on risk factors for diseases to the salutogenic focus on the strength and determinants for health was introduced (Antonovsky 1979, 1987).

Previously stress was seen as a negative event that increased the risk of breaking people down. Over time the understanding became more relative where the nature of the stress agent, the abilities of the people involved and the environment played important roles. Both health and stress research initially considered the stress factors (or stressors) as problematic negative events in people's lives. In contrast, Antonovsky stated that diseases and stress regularly occur all the time and it is surprising that an organism is able to survive at all for such a long time. His conclusion was that chaos and stress is part of life and natural conditions (Antonovsky 1991). The interesting question is how we can survive in spite of this or how we can manage the lack of control over our life? In his world, health becomes a relative

concept on a continuum and the really important research question is what causes health (salutogenesis), not what are the reasons for disease (patogenesis).

Conceptually, it seems Antonovsky seeks support from many other theoretical frameworks to synthesise the core concepts of salutogenesis. The fundamental new concepts are the generalised resistance resources (GRRs) and the SOC. The GRRs are biological, material and psychosocial factors that make it easier for people to perceive their lives as consistent, structured and understandable. Typical GRRs are money, knowledge, experience, social support, culture, intelligence, traditions, ideologies etc. If a person has these kinds of resources available herself or in her immediate surroundings there is a better chance for her to deal with the challenges of life. They help the person to construct coherent life experiences. What is more important than the resources themselves is this ability to use them, the SOC, the second and more generally known salutogenic key concept. The GRRs lead to life experiences that promote a strong sense of coherence – a way of perceiving life and an ability to successfully manage the infinite number of complex stressors encountered in the discourse of life. The SOC is the capability to perceive that one can manage in any situation independent of whatever else is happening in life. The SOC is a resource that enables people to manage tension, to reflect on their external and internal resources, to identify and mobilize them, to promote effective coping by finding solutions, and resolve tension in a health promoting manner. SOC is flexible and not constructed around a fixed set of mastering strategies (like the classic coping strategies) (Antonovsky 1993a).

In the original text the SOC is defined as "*as a global orientation that expresses the extent to which one has a pervasive, enduring though dynamic feeling of confidence that 1) the stimuli deriving from ones' internal and external environments in the course of living are structured, predictable and explicable; 2) the resources are available to one to meet the demands posed by the stimuli; and 3) these demands are challenges, worthy of investment and engagement"* (Antonovsky 1987).

People have to understand their lives and they have to be understood by others, perceive that they are able to manage the situation and, most importantly, perceive that it is meaningful enough to find motivation to continue. The salutogenic concept is a deeply personal way of thinking, being and acting, a feeling of an inner trust that things will be in order independent of whatever happens. The inner trust developed by internalising the SOC concept leads us to identify, benefit, use and re-use the general resistance resources from our surroundings. Three types of life experiences shape the SOC: consistency (comprehensibility), load balance (manageability) and participation in shaping outcomes (meaningfulness).

SOC is applicable on the individual, group and societal level and is fluctuating dynamically through life. Antonovsky postulated that SOC is mainly formed in the first three decades of life (Antonovsky 1987). Thereafter he thought that only very strong changes in life could upset and change the SOC. Speaking in general terms people who are approaching their fourth decade in life today have had enough experience of life to become independent persons with a job and an education, have enough experience of social structures and relationships and also formed a view of life. Antonovsky further boldly postulated the SOC was universally applicable to all cultures

and ethnic contexts. At the time of his death much of the empirical evidence to either support or refute his theories was not available. A year before his death he published an article that summarised the evidence up to 1992 (Antonovsky 1993a). Until now nobody has really tried to pull all the knowledge together in a systematic way.

2.12 Contemporary Evidence on SOC and Especially in Relation to Culture and/or Mental Well-Being, Quality of Life and Health

To date, the SOC questionnaire has been used in 33 languages in 32 countries on more than 200,000 subjects in studies varying from large samples of the general population covering 20,000 persons to small samples of 10–20 individuals (Eriksson and Lindström 2005). Most of the studies are cross-sectional, though there are also some longitudinal and intervention studies. SOC is strongly and negatively related to anxiety, burnout, demoralisation, depression and hopelessness and positively with hardiness, mastery, optimism, self-esteem, good perceived health, quality of life and well-being (Eriksson and Lindström 2005, 2006). SOC seems to be stable over time, at least for people with an initial high SOC, including fluctuations of about 10%. Furthermore, SOC tends to increase with age over the whole life span. Gender differences are found, men usually score higher on SOC than women.

SOC seems to have a main, moderating or mediating role in the explanation of health (Eriksson and Lindström 2006). Furthermore, the SOC seems to be able to predict health. The results are more consistent in relation to factors that measure mental health. There is a strong negative association between SOC and anxiety, anger, hostility and depression, and a positive association with optimism, hope, learned resourcefulness and constructive thinking. One conclusion of this would be that SOC is analogous with mental health.

The positive relationship between SOC and health seems to be relatively clear for individuals scoring high on SOC. A high SOC protects health, but we have no clear indication of where the cut off point is and where SOC loses this protective effect. There are many scales measuring quality of life and well-being among different groups of chronically or seriously ill people, people with disabilities and their families, and older people. Most of them report an association between SOC and quality of life, life satisfaction and well-being. The higher the SOC the more satisfied people are with their lives, and consequently report a higher level of quality of life and general well-being. Independent of the instrument used for measuring quality of life, life satisfaction and well-being, the results supports the salutogenic theory as a health promotional resource. However, the direction of the relationship and the causality is somewhat unclear, therefore further research is needed.

What people are at risk of developing poor health? Social class and social conditions have an effect on the individual health (Lundberg 1997). As a sociologist Antonovsky knew very well about the impact of social conditions on people's

health. Can the SOC concept be realized only by people with a high level of education, a good economy, a good social support, and social integration, an elite? We do not agree that SOC can only be the preserve of certain sections of society, and neither did Antonovsky. In a lecture at the Nordic School of Public Health in Gothenburg in 1993 he explicitly pointed out the responsibility of society to create conditions that foster the strengths of coping – that is, SOC. It is not question about a free choice of the person to cope well. The key lies in a society and in people who care about others (Antonovsky 1993b).

Maybe the empowerment concept, which is a supporting process whereby groups or individuals are enabled to change a situation, given skills, resources, opportunities and authority, could be seen as a tool for the enhancement of the individual SOC (Koelen and Lindström 2005). Unfortunately the association between empowerment and SOC has not been completely clarified. However, one example is the testing of a home-computing model for children with learning disabilities. It was found that such a model empowers both parents and children as well as strengthening their SOC (Margalit et al. 1995).

One of the most fundamental elements of the empowerment concept is participation of individuals or groups. This enhances peoples' understanding of what happens around them and shapes a sense of control of the situation. In health promotion activities and in clinical practice the empowerment of people could be accomplished through the practice of a clinical communication based on the salutogenic approach or a resource-oriented discussion as described by Malterud and Hollnagel (1998, 1999). This relates back to the discussion on learning earlier described in this chapter. One of the GRRs that generates the SOC is wealth, i.e. economy both at an individual and community level. SOC is clearly related to socioeconomic factors (Lundberg 1997). The higher the income level the stronger the SOC.

Antonovsky never asserted that SOC was the only and unique property to explain the movement towards health. There are other related concepts which contribute to the understanding of the health process such as hardiness (Kobasa), sense of permanence (Boyce), the social climate (Moos), resilience (Werner) and the family's construction of reality (Reiss) all mentioned by Antonovsky (Antonovsky 1987). Additional concepts which he did not discuss and which resemble SOC's connection to health are learned resourcefulness, (Rosenbaum 1990) flow, (Csíkszentmihályi and Csíkszentmihalyi 1998) theories on welfare/well-being, (Allardt et al. 1980) quality of life (Naess 1987; Lindström 1994) and theories considering people in their social and cultural context (Bourdieu 1993; Klein 1990; Swedner 1983; Bronfenbrenner 1979).

The last 25 years of research has provided strong empirical support for the SOC theory. The analysis of variance shows that SOC is strongly related to health, especially mental health. The rest of the variance is explained or accounted for by other factors like age, social support, and education. The interpretation could be that SOC is not the same as health but is still an important disposition for people's development and maintenance of their health (Eriksson and Lindström 2006). The salutogenic orientation provides no prescription for a good life in the moral sense of the term; it can only help us understand health and illness (Antonovsky

1995). Furthermore, the potential of the salutogenic concept lies in its implications for creating societies that adopt a healthy public policy, where the content and the structure of all services are salutogenic, rather than a healthy policy only for the health services. It is important to strengthen available resources and to create new kinds of general resistance resources to make it possible for the citizens to identify and benefit from them. Maybe it is also time to consider a change of the original WHO declaration on health and adopt the salutogenic perspective in a revised definition. The authors of this chapter would willingly contribute to such a discussion.

Public health has largely operated within risk reduction framework. Identifying causal factors for disease and, together with medical science, searched for logical interventions to eliminate them. The history of this approach is as long as the history of public health, successful in simple causal relationships but finding it increasingly difficult to deal with more complex problems, sometimes even failing to solve them (e.g. the HIV/AIDS epidemic). However, if one could identify public health interventions directed towards the post-modern mechanisms there are perhaps other solutions available. Out of the new theories on health and life management, two themes have evolved.

Firstly, the salutogenic approach which claims health is open ended and dependent on the skills to organise the resources available in society, the social context and self. This capability has been named the sense of coherence (Allardt et al. 1980).

Secondly, the theme of resilience claiming there are certain patterns of interaction between the individual and his social context that develop hardiness against stress and the ill-health that could follow (Campbell et al. 1976).

Both resilience and sense of coherence, it is claimed, are developed mainly in childhood. Resilience theory addresses the post-modern issue of abstract systems alienating the individual from trust in self and local context. The essence of the literature of resilience focuses on the development of the reflective dialogue between the child and its social context. Salutogenesis again addresses mechanisms that enable people and populations to develop their health and deal with the fragmentation and chaos of reality through their senses of cognitive and emotional perception, behavioural skills and motivation through meaningful frameworks based on culture, tradition and belief systems. The combination of the two could perhaps guide public health and the children of the post-modern society towards a positive synthesis. The effect is that public health could make progress in an area where it has been least successful addressing social and mental well-being in a long-term perspective by the focus on prerequisites for quality of life (Andrews and Whitney 1976).

The contemporary knowledge base in health science claims that what we perceive as being good for ourselves (the sense of subjective well being) also predicts our positive outcome in objective health parameters, in other words, if we create processes where people perceive they are able to live the life they want to live, people will not only feel better but will also lead better lives. From a public health perspective there is of course not only a pursuit of an individual's good life, but the good life of populations, including future generations.

References

Allardt, E. (1980). Att, Ha., Att, Älska., Att, Vara: Om välfärd i Norden. Borgholm: Argos.

Andrews, F. M., & Whitney, S. B. (1976). *Social indicators of well-being: The development of and measurement of perceptual indicators.* New York: Plenum.

Antonovsky, A. (1979). *Health, stress and coping.* San Francisco: Jossey-Bass.

Antonovsky, A. (1987). *Unraveling the mystery of health. How people manage stress and stay well.* San Francisco: Jossey-Bass.

Antonovsky, A. (1991). The salutogenic approach to family system health: promise and danger. In: *European congress on "Mental Health in European Families"*; p.9. http://www.angelfire.com/ok/soc/agolem.html cited May 2009.

Antonovsky, A. (1993a). The structure and properties of the sense of coherence scale. *Social Science & Medicine*, 36(6):725–733.

Antonovsky, A. (1993b). Some salutogenic words of wisdom to the conferees. In: *The Nordic School of Public Health in Gothenburg, Sweden*; p.3. http://www.angelfire.com/ok/soc/agoteborg.html cited May 2009.

Antonovsky, A. (1995). The moral and the healthy: Identical, overlapping or orthogonal? *Israel Journal of Psychiatry and Relative Science*, 32(1):5–13.

Atkinson, T. (1982). The stability and validity of quality of life measures. *Social Indicators Research*, 10:113–132.

Bauman, Z. (1989). *Modernity and the holocaust.* Cambridge: Polity.

Bourdieu, P. (1993) *The field of cultural production. Essays on art and literature.* Cambridge: Polity.

Bowlby, J. (1979). *The making and breaking of affectional bonds.* London: Tavistock.

Bronfenbrenner, U. (1979). *The ecology of human development – experiments by nature and human design.* Cambridge, MA: Harvard University Press.

Campbell, A., Converse, P. E., & Rodgers, W. L. (1976). *The quality of American life: Perceptions, evaluations and satisfactions.* New York: Russell Sage.

Crowne, D. P., & Marlowe, D. (1964). *The approval motive. Studies in evaluative dependence.* New York: Wiley.

Csíkszentmihályi, M., & Csíkszentmihalyi, I. S. (1998). *Optimal experience. Psychological studies of flow in consciousness.* Cambridge: Cambridge University Press.

de Leeuw, E. (2003). Nurturing healthy cities: research responsibility and accountability. In: Takano, T., editor. *Healthy cities & urban policy research.* London: Spon.

de Maio, T. J. (1984). Social desirability and survey measurement: A review. In: Turner, C. F., Martin, E., editors. *Surveying subjective phenomena.* New York: Russell Sage, pp. 257–282.

Dencik, L. (1989). Growing up in postmodern age: On the child's situation in the modern family and on the position of the family in the modern welfare state. *Acta Sociologica*, 32(2):155–180.

Eriksson, M., & Lindström, B. (2005). Validity of Antonovsky's Sense of Coherence Scale – a systematic review. *Journal of Epidemiology and Community Health*, 59(6):460–466.

Eriksson, M., & Lindström, B. (2006). Antonovsky's Sense of Coherence Scale and the relation with health – a systematic review. *Journal of Epidemiology and Community Health*, 60:376–381.

Flanagan, J. C. (1982). Measurement of quality of life: Current state of the art. *Archives of Physical Medicine and Rehabilitation*, 63:56–69.

Fonagy, P., Steele, M., Higgit, A., et al. (1994). The Emanuel Miller Memorial Lecture 1992. The theory and practice of resilience. *Journal of Child Psychology and Psychiatry*, 35(2):231–257.

Freire, P. (1970). *Pedagogy of the oppressed.* Harmondsworth: Penguin.

Gardner, H. (1991). *To open minds.* New York: The Perseus Books Group.

Giddens, A. (1990). *The consequences of modernity.* Cambridge: Polity.

Giddens, A. (1991). *Modernity and self-identity. Self and society in the late modern age.* Cambridge: Polity.

Ingelhart, R., & Rabier, J. -C. (1985). If you are unhappy this must be Belgium: Well-being around the world. *Public Opinion*, 8(2):10–15.
Jahoda, M. (1958). *Current concepts of positive mental health.* New York: Basic Books.
Johansson, S. (1970). *Om levnadsnivåundersökningen*. Stockholm: Allmänna Förlaget.
Kajandi, M. (1981). Allmän översikt över forskningsområdet. Livskvalitet – en litteraturstudie av livskvalitet som beteendevetenskapligt begrepp samt ett förslag till definition. Uppsala: Forskningskliniken.
Klein, J. (1990). *Interdisciplinarity: History, theory and practice.* Detroit: Wayne State University Press.
Koelen, M., & Lindström, B. (2005). Making healthy choices easy choices: the role of empowerment. *European Journal of Clinical Nutrition*, 59(Suppl 1):S10–S16.
Lazarus, R., & Lannier R. (1979). Stress-related transactions between persons and environment. In: Pervin, L., Lewis, M., editors. *Perspectives in international psychology.* New York: Plenum, pp. 142–156.
Lindström, B. (1994). The essence of existence. On the quality of life of children in the Nordic countries – theory and practice in public health (Doctoral thesis). Göteborg: Nordic School of Public Health.
Lindström, B., & Nafstad, A. (2003). On the origin of salutogenesis. In: *The 4th Nordic health promotion research conference* 10–13 June. Västerås, Sweden; 2003.
Lundberg, O. (1997). Childhood conditions, sense of coherence, social class and adult ill health: Exploring their theoretical and empirical relations. *Social Science and Medicine*, 44 (6):821–831.
Mahler, H. (1987). The role of schools of public health in the development of public health. In: Köhler, L., editor. *Public Health – a Nordic Perspective.* In Swedish. Gothenburg: Nordic School of Public Health.
Malterud, K., & Hollnagel, H. (1998). Talking with women about personal health resources in general practice. Key questions about salutogenesis. *Scandinavian Journal of Primary Health Care*, (16):66–71.
Malterud, K., & Hollnagel, H. (1999). Encouraging the strengths of women patients. A case study from general practice on empowering dialogues. *Scandinavian Journal of Public Health*, 27:254–259.
Margalit, M., Rochberg, Y., & Al-Yagon, M. (1995). Home-computing model and children with learning disabilities: A systemic approach. *Learning Disability Quarterly*, (18):68–75.
Mastekaasa, A., Moum, T., Naess, S. (1988). Livskvalitetsforskning. Oslo: ISF Rapport 88:6.
Naess, S. (1974). Psykologiske aspekter ved livskvalitet: om begrepet "indre livskvalitet" som mål for sosialpolitikken og om et forsök på å operasjonalisere begrepet. Oslo: Institutt for anvendt sosialvitenskapelig forskning.
Naess, S. (1979). Livskvalitet: om å ha det godt i byen og på landet. Oslo: Institutt for anvendt sosialvitenskapelig forskning.
Naess, S. (1987). Quality of life research: Concepts, methods and applications. Oslo: Institute of Applied Social Research.
Nilsson, L. (2003). The encounter between health promotion and schools in theory and in practice. In Swedish (Doctoral thesis). Örebro: Örebro University.
Nutbeam, D. (1993). Advocacy and mediation in creating supportive environments for health. *Health Promotion International*, 8:165–166.
OECD. (2009). *Society at a Glance 2009 – Organisation for Economic Cooperation and Development Social Indicators.* www.oecd.org/els/social/indicators/SAG cited May 2009.
Raphael, D. (2002). Evaluation of quality of life initiatives in health promotion. In: *Evaluation in health promotion*. Geneva: WHO.
Rappaport, J. (1987). Terms of empowerment/exemplars of prevention: Toward a theory for community psychology. *American Journal of Community Psychology*, 15:121–148.
Resnick, M. D., Bearman, P. S., Blum, W., et al. (1997). Protecting adolescents from harm. Findings from the National Longitudinal Study on Adolescent Health. *JAMA*, 278(10):823–832.
Ringen, S. (1988). *Approaches to the measurement of welfare*. Oslo: Statistisk Sentralbyrå.
Rootman, I., Raphael, D., Shewchuk, D., et al. (1992). *Development of an approach and instrument package to measure quality of life of persons with developmental disabilities.* Toronto: University of Toronto, Centre for Health Promotion.

Rosenbaum, M. (1990). *Learned resourcefulness. On coping skills, self-control, and adaptive behaviour.* New York: Springer.
Rutter, M. (1980). *Changing youth in a changing society. Patterns of adolescent development and disorder.* London: Harvard University Press.
Rutter, M. (1985). Resilience in the face of adversity. *British Journal of Psychiatry*, 147:598–611.
Shalock, R. L. (1990). *Quality of life.* Washington, DC: American Association on Mental Retardation, Special Publications.
Swedner, H. (1983). *Social work – a framework for thought.* In Swedish. Stockholm: Liber. 18. Swedner, H. (1983). Socialt arbete – en tankeram. Stockholm: Liber.
Turnbull, C. M. (1961). *The forest people.* New York: Simon & Schuster.
Turnbull, C. M. (1972). *The mountain people.* New York: Simon & Schuster.
Veenhofen, R. (1991). Questions on happiness. In: Strack, F., Argyle., M., Schwarz, N., editors. *Subjective well-being.* Oxford: Pergamon.
Ventegodt, S. (1995). *Livskvalitet i Danmark. Resultater fra en befolkningsundersögelse*. Köpenhamn: Forskningscentrets Forlag.
Werner, E., & Smith, R. (1982). *Vulnerable but invincible. A longitudinal study of resilient children and youth*. New York: McGraw Hill.
Werner, E., & Smith, R. (2001). *Journeys from childhood to midlife. Risk, resilience, and recovery.* Ithaca: Cornell University Press.
Whitehead, M., & Diderichsen, F. (2001). Social capital and health: Tip-toeing through the minefield of evidence. *Lancet*, 358:165–166.
WHO. (1986). The Ottawa charter. Geneva: World Health Organization.
WHO. (1946). Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19–22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948.

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