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Resilience in the Salutogenic Model of Health

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Introduction

This chapter discusses the question, how does the salutogenic model of health (Antonovsky, 1979, 1987) address the concept resilience? Others have raised this question. Looking for links between resilience and a salutogenic orientation to health, Eriksson and Lindström (2006, 2010) summarized that (a) both are understood as processes (rather than personal attributes); (b) in both, resources/assets play key roles in coping; (c) they are both meaningful at multiple levels (individual, group, community); and (d) a strong sense of coherence (the key construct of salutogenesis) is a resource for resilience. Others have concluded that salutogenesis is a relevant framework for therapy and counseling to promote resilience (Langeland & Vinje, 2016; Vossler, 2012). It is not surprising, then, that the ideas of human resilience and sense of coherence, which is a key construct in salutogenesis, fit within a broad family of concepts that have assets/resources for well-being in common. Other concepts include hardiness, self-efficacy, optimism, hopefulness, and action competence, among other human strengths (Eriksson & Lindström, 2010).

Since resilience and salutogenesis share so many features, it may seem strange that the scientific literature on one hardly refers to the other. Alternatively, perhaps the lack of connection is not so strange. The main academic fields concerned with the study of human resilience are social work, psychiatry, clinical psychology, developmental psychology, and disaster preparedness. The main fields concerned with the study of salutogenesis are health promotion, community development, organizational psychology, and nursing science. As we shall see, resilience and salutogenesis researchers address different research problems at slightly different systemic levels. Suffice it to note for the moment that the two fields touch, and even overlap, but they remain distinctive. How they relate is the main subject of this chapter.

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I turn first, however, to a discussion of the meaning of the concepts resilience and salutogenesis. Both terms—and especially *resilience*—have a range of meanings and usage in science, so that a meaningful discussion of resilience depends on a meticulous paring down of the term (Kaplan, 2013; Ungar, 2012; van Breda, 2018; Wright & Masten, 2015).

Resilience

Here, the term *resilience* refers to transdisciplinary theory and research aiming to develop, test, and disseminate interventions that increase the coping capacity of individuals, households, and groups that experience significant and atypical adversity or deprivation. Adversity in this sense means significant hardship forged by social conditions (Dagdeviren, Donoghue, & Promberger, 2016). Theory and research on structural interventions to assist society in coping with disaster and catastrophe is excluded for present purposes, even if the term *resilience* is used in this arena. Also excluded is resilience scholarship focused on living systems without an anthropocentric focus (e.g., animals and plants).

The delimitation of individuals, households, and groups who experience atypical adversity or deprivation is essential. As Ungar (2012) expresses it in his ecological model, resilience is a set of observable behaviors associated with adaptive outcomes in contexts of *exposure to significant adversity*. The study of resilience defined this way is the investigation of biopsychosocial-ecological processes (the interplay of intrapersonal factors and one's ecological context) that give expression to particular behaviors that signal resilience. For example, resilience may be inferred when a young person does not drop out of schooling despite living under conditions of deprivation in which dropping out of school is a notable risk. In research on humans, resilience is inferred from observation of living conditions and behaviors in particular circumstances. It cannot be assessed directly, though, and its expression is fluid, depending on the conditions of the study.

Attention to the individual, as previously described, is, however, an oversimplification. Resilience, as understood here, has three components: (a) exposure to significant adversity; (b) a set of behaviors (outcomes) that signal coping; and (c) a set of multilevel processes that result in degrees of coping.

Resilience processes are the main subject of two recent systematic analyses of theory on human resilience: Ungar's (2018) principles of systemic human–environment resilience and Shean's (2015) comparative analysis of mainline theories focused on resilience in young people.

Ungar's (2018) analysis has the aim of identifying resilience principles that emerge from the theoretical and empirical transdisciplinary literature. Ungar understands systemic resilience in a particular way that is crucial to the present analysis: resilience in a given subsystem may confer resilience in another subsystem. Such interventions are themselves a resilience subsystem, and their influence may be reciprocal: children staying in school may contribute to the quality of family life. This idea of subsystem interrelatedness is important, as a similar idea underlies the salutogenic model of health. The following are principles of resilience theory, followed by an overview of salutogenesis theory to demonstrate points of agreement and disagreement between the two concepts.

Ungar's analysis of resilience processes aims to identify a set of principles that explain resilience among co-occurring systems (Ungar, 2018). The analysis has as its starting point previously published syntheses (and related material and experts' comments).

Shean's (2015) analysis is a comparative examination of the work of six theorists in the field of human resilience: Michael Rutter, Norman Garmezy, Emmy Werner, Suniya Luthar, Ann Masten, and Michael Ungar. She identifies several points of convergence (and also of divergence) that seem evident amongst the main resilience models/theories she examined. The points of convergence are in synchrony with several of Ungar's principles. Resilience, as addressed by Ungar and by Shean, includes six key features. An abbreviated synthesis of their conclusions follows:

- The study of resilience focuses on several processes of coping with adversity/deprivation, involving the person and her environment (more so than on characteristics of people or of groups, or outcomes of coping):
  - A persistence process by which a system may undertake change to maintain functioning in the face of stressors;
  - A resistance process whereby a system at risk of being overcome by stressors may use resources to continue functioning;
  - A recovery (bounce back) process whereby a system may undergo rebuilding, repair, and adaptation to return to normal functioning;
  - An adaptation process whereby a system under stress may learn new ways of functioning to be sustainable; and
  - A transformation process whereby a system under stress changes in a fundamental way, as compared to adaptation for sustainability (adapted from Ungar, 2018).
- The study of resilience focuses on the experience of individuals, groups and communities experiencing atypically severe adversity/deprivation. Resilience is, therefore, *not* a population-level phenomenon.
- In the study of resilience, a person who does well in life (copes well) despite experiencing atypical adversity/deprivation is considered to be resilient. Doing well is defined diversely, in concert with researchers' study questions.
- The influences of one's social context and one's cultural context are critically important determinants of one's resilience.
- The study of resilience has the primary aim of informing interventions to increase the coping capacity of person's who experience atypical adversity/deprivation.
- Resilience scholarship addresses multilevel systems that contribute to individuals' experience of coping with atypical adversity/deprivation. Multilevel systems are open, dynamic, and complex and exhibit redundancy, connectivity, adaptation, and experimentation (Chapter 1 of this volume explains these concepts further).

The term *resilience* does not have a formal place among the concepts of the salutogenic model of health. Therefore, to address the question posed at the beginning, one must search for concepts in the salutogenesis theory literature that correspond to resilience processes.

Salutogenesis

Aaron Antonovsky, the originator of the salutogenesis concept, viewed the concept of resilience to be compatible with salutogenesis (Antonovsky, 1987, p. xv). In his earliest exposition of salutogenesis, Antonovsky wrote: "[S]alutogenesis asks . . . how can it be explained that a given individual, in this miserable world of ours, has not broken down? Or, in a group version, how come this group has such a relatively low proportion of people who have broken down?" (Antonovsky, 1979, pp. 55–56). His research and theorizing were motivated initially by the impressive coping capacity of individuals who experienced extraordinary adversity. When it came to the explication of salutogenesis as formal theory, he contended that we are all, always, in the rough and tumble river of life. The salutogenic model of health, to which I now turn, was formulated to explain the origins and progression of health in every human being, not just those experiencing atypical adversity/deprivation.

The salutogenic model of health is presented in detail in two books authored by Antonovsky published in 1979 and 1987, and further developed by him in many published papers until his passing in 1994, including the posthumous publication in which Antonovsky proposed salutogenesis as a theory for health promotion (Antonovsky, 1996). There is no doubt that momentum in salutogenesis's development as a theory of health faltered somewhat with his untimely death in 1994. In the decades since, the momentum has been recovered. The community of scholars working with the salutogenic model of health has grown appreciably, contributing to a burgeoning theoretical and empirical literature (Bauer et al., 2019).[1]

The salutogenic model of health is a systems theory, drawing on an eclectic range of biological, psychological, sociological, anthropological, and measurement theories that Antonovsky considered essential to his developing idea about the origins of health (Antonovsky, 1979, 1987). He understood coping resources as properties of the ecosystem and not just the individual. Furthermore, his delineation of the theory of salutogenesis was undertaken as a systems analysis.

The starting point is the proposition that experience throughout life (but especially the earliest years) shapes one's orientation to life, one's sense of coherence. The sense of coherence, which is one of two key constructs of the theory, is a subjective viewing/interpreting lens, through which life may be experienced as more or less comprehensible, manageable, and meaningful. A strong sense of coherence facilitates the adaptive use of resources to tackle life's ubiquitous stressors. Expounding on the concept of resources, Antonovsky coined the term "generalized resistance resources," which is the other key construct in the salutogenic model of health (Antonovsky, 1979). These are properties/characteristics of a person, group, or community that facilitate an individuals' or group's ability to cope effectively with stressors and contribute to the development of the sense of coherence (Idan, Eriksson, & Al-Yagon, 2017). Examples of generalized resistance resources are knowledge, skills, coping strategies, materials, social relationships and support, cultural stability, and genetic and constitutional factors.

The relationship between the sense of coherence and generalized resistance resources is reciprocal, the one strengthening or weakening the other. A strong sense of coherence

mobilizes resources to confront potentially serious stressors through processes including evaluating them as not serious, avoiding them, or actively managing them (tension management). Successful tension management strengthens the sense of coherence and helps one stay-in-place along ease/dis-ease continua (e.g., health, good social functioning, well-being). Ease/dis-ease continua (not *disease*) indicate a sliding range of functioning from good to poor, contra the dichotomous medical diagnostic classification "ill–not ill."

Many in the field of health promotion have embraced the salutogenesis model as a framework for intervention to help people gain control over the own health. The application of salutogenesis has been described in settings as diverse as neighborhoods, schools, workplaces, prisons, hospitals, and residential care facilities (Mittelmark et al., 2017). Thus, the salutogenic model of health, initially a descriptive model, has evolved into an intervention model. Like resilience scholarship, much of salutogenesis scholarship is today oriented to the study of social change to improve quality of life.

Comparing Resilience Scholarship and the Salutogenic Model of Health

Processes

The study of processes characterizes both traditions, as Eriksson and Lindström (2010) observed, yet there are important differences. Resilience scholarship is focused on transactional processes involving person and environment, which Ungar (2018) terms *persistence*, *resistance*, *recovery*, *adaptation*, and *transformation*. Absent is an emphasis on mental processes involved in appraisal, judgement, and reaction to potentially stressful stimuli, processes associated with neurological functioning. In explaining how one person does well under fundamentally the same adverse circumstances under which another person does less well, resilience scholarship pays little attention to how intrapersonal factors affect the unfolding of those processes. The focus is, instead, on environmental factors. As Hadfield and Ungar (2018) put it, the focus is on coping resources in proximal (family) and distal (community) systems. This is understandable in applied mental health fields where the aim is to intervene to help people living in adverse situations do well. Social and physical environment that offers opportunities for intervention and change. Intrapersonal (individual) differences are admitted but offer no intervention opportunities except individually focused therapy. In other words, the emphasis in much of the resilience literature is not on altering intrapersonal factors, but on altering the person's living situation.

This is in contrast to counseling research applying salutogenesis, which aims to strengthen a particular intrapersonal factor: the sense of coherence. Clinical interventions to strengthen the sense of coherence in people with mental health challenges have been used to achieve outcomes such as increasing tolerance for disturbing feelings, experiencing oneself more positively as a person, improving one's self-identity, increasing one's perception of the quality of social support, and developing one's perceptions of life's comprehensibility, manageability, and meaningfulness (Langeland & Vinje, 2016). These changes in cognitions and emotions distinguish salutogenic interventions from the environmental interventions

promoted by resilience researchers. This is not to underplay that much intervention stimulated by salutogenesis aims, as resilience interventions do, to increase the availability and quality of environmental coping resources (creating supportive environments).

Severe Adversity

Resilience scholarship focuses on the needs of individuals, groups, and communities experiencing atypically severe adversity/deprivation. It does not, therefore, address whole populations. Resilience researchers seek to understand the needs and challenges of especially vulnerable people and groups and help them to cope. Children living in disadvantaged conditions that put them at risk of school dropout, for example, exemplifies the concern at the heart of resilience scholarship. School dropout among disadvantaged children is a serious aberration of societal aspirations. It is to be prevented. The task of building at-risk children's resilience to dropout through effective interventions is an example of the challenge that motivates resilience research. The focus of intervention is not so much the at-risk child herself as her home, community, and societal environments. Yet the raison d'etre of intervention should be to help particular at-risk children cope better.

Salutogenesis, on the other hand, has as its starting point the idea of "the river of life." It is a misconception, in salutogenic eyes, that most people are safely ashore, and it is therefore sufficient to erect barriers to prevent people from falling into the river and provide rescue services to save those who do stumble in. Salutogenesis takes the perspective that all people are born into the river of life and must learn to swim and to navigate and tackle the dangers and obstacles that are unavoidable aspects of life (Antonovsky, 1987). No one is on the shore, yet the river is not uniformly challenging. Some people do find themselves situated at particularly hazardous parts of the river, they are at alarming risk of foundering, and they need urgent help. Resilience and salutogenesis thus have complementary but not indistinguishable concern with the struggle for survival. It is this distinction, between concern for at-risk subgroups and attention to the population as a whole, which most cogently illustrates the fundamental divide between the interests of resilience and salutogenesis scholarship. From a salutogenesis perspective, one could consider that resilience interventions, and the entire field of resilience scholarship, are concerned with providing effective and *specific* resistance resources that match a person's needs at particular times (Mittelmark, Bull, Daniel, & Urke, 2017).

Doing Well Despite Adversity

The outcomes of interest in resilience research are varied, but they share the characteristic that they are indicators of "doing well" under adverse conditions. In the child development arena, for example, resilience under adverse conditions is recognized by a child's achievement of positive developmental outcomes and the avoidance of maladaptive outcomes (Rutter, 2006). Doing well for such children is no different from doing well for all children, meaning that the goal of resilience-promoting interventions is, according to Wright, Masten, and Narayan (2013), to meet

> the expectations for children of a given age and gender in their particular sociocultural and historical context. Competence is typically assessed by how well the

> child has met, and continues to meet, the expectations explicitly or implicitly set in the society for children as they grow up. This is often referred to as the child's track record of success in meeting developmental tasks, age-related standards of behavior across a variety of domains, such as physical, emotional, cognitive, moral, behavioral, and social areas of achievement or function. (p. 18)

While the concept of doing well is relevant to all people, the special interest of resilience scholarship is to assist people living in particularly adverse conditions to do well. Adverse conditions in this sense are exemplified by the experience of poverty, unemployment, violence, crime, family breakdown, and substance abuse. In salutogenesis scholarship, extreme conditions like this cause deep consternation, but the main thrust of the theory is the notion that *all* people live in the rough and tough river of life from birth to death. In the spirit of the salutogenic model of health, resilience (when the term is used) is the essence of every human life, the entire process of experiencing life whether one is at-risk or not, acquiring resources, meeting stressful conditions, coping, building a sense of coherence, and having one's health and well-being affected positively.

As to the concept of "doing well," salutogenesis scholars have evolved ideas about what it may mean. In Antonovsky's (1979) exposition of the theory, doing well meant moving toward the ease end of an ease/dis-ease continua. His interest was focused on a health continuum defined by the degrees to which one experiences pain, has functional limitations, has a medical condition with prognostic implications, and whether one needs medical treatment. However, he was open to other continua having relevance to positive functioning, flourishing, and well-being (Antonovsky, 1996).

Cultural Contexts

Social and cultural contexts play an important role in conferring resilience. As put by Ungar (2012), resilience scholars aim to "explore the context in which the individual experiences adversity, making resilience first a quality of the broader social and physical ecology, and second a quality of the individual" (p. 27). The implications of this viewpoint are profound. It calls for intervention to create (and treat as outcomes in research) supportive social and physical environments, and not just intervention to change the individual (Ungar, 2011). It urges caution in generalizing findings from any particular context to other contexts. It acknowledges the possibility that coping may be manifest in atypical and unexpected ways. It calls for scholars to seek understanding of resilience from the perspective of nondominant cultural groups who are at heightened risk compared to dominant cultural groups.

Thus, resilience scholarship is called to be highly sensitive to the role of cultural context in resilience processes. This is in complete synchrony with the salutogenic model of health, in which culture is understood to be a constant force on health, from conception to death. This is especially evident among people who confront the challenge of engaging with several distinct cultures at once as Riedel, Wiesmann, and Hannich (2011) point to in their work on salutogenesis, acculturative stress, and mental health.

The explicit starting point in Antonovsky's (1979) model is the person's sociocultural and historical context. Antonovsky theorized that cultural context influences the

development of health at every phase of the salutogenic process (Benz, Bull, Mittelmark, & Vaandrager, 2014). First, while stressors are ubiquitous in all cultural contexts, they are differently distributed and perceived between cultures. Second, stressors connected explicitly to culture include minority background, rapid culture change, and gaps between aspirations and achievements that are exacerbated by culture. Third, cultures generate (more or less) general resistance resources following from degree of cultural stability, being valued for one's culture, and being integrated into society. Fourth, life experience is shaped in part by cultural stability, consistency, and personal and social achievement. Fifth, a sense of coherence is shaped by all the aforementioned cultural factors (but is not culture-bound). Finally, one's understanding of the concept of well-being is influenced by culture. For example, one's religiosity may play an important role in how one defines what is meant by the idea of the "good and worthy life."

In more recent formulations of salutogenesis, the level of analysis has expanded to include the family and the community, with key variables like the sense of coherence measured at several levels (Mana, Sagy, & Srour, 2016). Research on social relations at the community level has had a decidedly cultural orientation, as in the study of in- and out-groups' community sense of coherence and their degree of openness to other cultures. Recall from the previous discussion of resilience that due to contextual factors, coping may be manifest in atypical and unexpected ways: the possibility for this is startlingly obvious in research with Palestinian Muslims and Christians in Israel where a strong community sense of coherence was correlated with higher levels of acceptance of the in-group's collective narratives and with lower levels of acceptance of the out-group collective narratives, which were often stigmatizing or otherwise threatened well-being (Mana et al., 2016). Ungar (2011) has written about the complexity of resilience due to contextual factors, and the complexity of salutogenesis due to culture is correspondingly evident. For example, the roles of personal and of community sense of coherence in influencing well-being may differ significantly in Western-oriented societies compared to collectivist societies (Braun-Lewensohn & Sagy, 2011).

Whatever factors may differentiate resilience and salutogenesis, one thing is clear: these two areas of study are in complete agreement that coping is complex and culturally and contextually bounded. As a consequence of this insight, both bodies of research are committed to socioecological (multilevel) approaches to descriptive and intervention research. While a discussion between a resilience researcher and a salutogenesis researcher might reveal a number of areas of misapprehension, they would quickly come to agreement about the core roles of context and culture in shaping coping phenomena.

Conclusion

I now turn to the question this chapter is meant to address: How does the salutogenic model of health address the concept resilience? A too facile answer is that it does not, or that the term *resilience* has no place in the model. Yet, when resilience is characterized in terms of its main principles, it is evident that several features of the salutogenic model of health map on to resilience with a high degree of complementarity.

Regarding consideration of social and cultural contexts, resilience, and salutogenesis scholarship could hardly be in closer kinship. Both are systems oriented, and cognizant that the social challenges they address are complex and multilevel. Both are keenly sensitive to cultures as the cauldrons of life experience. Both encounter the complexity and frustration of attempting to do quality social research, wherein simple cause–effect analyses are wholly inadequate. Both face the challenge that arises when the need to tackle complexity across systems with a degree of specificity triumphs the wish to achieve broader generalizability.

Regarding social change, both bodies of research are incontrovertibly committed to informing intervention, while still recognizing that high-quality intervention development and dissemination depends on a bedrock of descriptive research that establishes the dimensions and contours of complex social problems.

Are resilience and salutogenesis siblings or cousins? *Cousins* seems to be the better response as the concepts differ significantly on two important dimensions. First, while both are concerned with the study of processes and not just associations, resilience scholarship deals in an almost piecemeal way with a range of coping processes having relevance to multiple stages/phases/aspects of coping—persistence, resistance, recovery, adaptation, and transformation. There is as yet no formal theory that accounts for these processes in an integrated manner. Readers of the resilience literature might be able to piece together a serviceable, integrated understanding of resilience-as-process, but no theoretician has yet undertaken the task, as far as I am aware. It is also noteworthy that resilience scholarship has not evidenced discipline-wide interest in how the human brain is the mediator of environment–person interaction (for an exception, see Kalisch, Müller, & Tüscher, 2015), that experience is therefore forged in the brain and that understanding how the brain creates experience is essential to understanding resilience and individual and community levels. In other words, resilience scholarship seems to eschew cognition in its research on resilience processes. Probably all resilience researchers would agree that "something is happening up there" that influences resilience, but they do not prioritize studying it.

Salutogenesis does have a formal theory, the salutogenic model of health. It postulates one main mediator in the link between environment and coping behavior—the sense of coherence. It elaborates pathways in which experience from the cradle to the grave gives meaning to life and imparts deeply held impressions about life's comprehensibility and manageability. It postulates that one's life orientation influences one's perceptions of coping resources, how stressors are experienced and appraised, and what coping actions/adjustments are possible/desirable/inevitable under the labile circumstances of one's own life.

Finally, resilience and salutogenesis scholarship differ sharply regarding the social situations they are concerned with. Resilience scholarship aims to help particular people do well despite living in risky life situations characterized by atypical adversity/deprivation. Salutogenesis considers that all people live in risky conditions—the river of life. Salutogenic processes are thereby equally relevant to those living lives of atypical adversity *and* those having all other manifestations of experience.

What opportunities for mutual enrichment might there be? Might salutogenesis research benefit from examining the resilience processes of persistence, resistance, recovery, adaptation, and transformation, to shed additional light on mechanisms by which potential

stressors are managed? Might resilience research benefit from examining the sense of coherence, to shed additional light on the mediating processes by which environment and person interact to develop or weaken resilience? Future efforts to draw these fields of study closer together can only be of benefit to the health sciences.

Key Messages

1. Resilience scholarship focuses on coping processes in persons and groups who experience severe adversity and deprivation, while salutogenic processes are posited to be descriptive of coping in all persons.
2. Resilience scholarship has always had a focus on developing interventions to help people do well in life despite barriers, while salutogenesis has until recently been more concerned with descriptive research.
3. Resilience and salutogenesis share the perspective that coping is culturally and contextually bounded.
4. Resilience scholarship is principled, but no single, articulated theory is dominate. Salutogenesis is well developed as theory, following the scholarship of Aaron Antonovsky.
5. The concept resilience does not have a formal place in salutogenesis theory, yet when salutogenesis scholars focus on coping under conditions of severe adversity, they apply resilience approaches and strategies, even if the concept resilience is not explicit.

Note

1. As of this writing, salutogenesis' advancement is buoyed by a recently inaugurated scientific organisation, The Society for Theory and Research on Salutogenesis—STARS, at https://www.stars-society.org. The Center of Salutogenesis at the University of Zurich play a key global coordinating role in advancing salutogenesis scholarship. Annual salutogenesis scientific meeting and conferences attract scholars worldwide, and several thousand papers and books populate a rapidly expanding literature. The Handbook of Salutogenesis (Mittelmark, et al., 2016) describes the history of salutogenesis and recent developments in theory and practice in community and healthcare settings in many countries.

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