Resources revisited: salutogenesis from a lay perspective

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Resources revisited: salutogenesis from a lay perspective

Health visitors are being pressured to move away from their traditional role in health promotion and public health to focus more closely on people with established clinical disorders. This is partly because of a paucity of theoretical explanations against which to assess interventions directed explicitly at promoting health rather than only preventing disease. However, there are growing public health concerns about increasing inequalities and rising numbers of disadvantaged groups in the UK as well. This paper revisits a grounded theory study that revealed how, in the absence of a need for clinical intervention, health visitors appear to assess needs by treating health as a process fuelled by the accumulation and use of 'resources for health'. Wider theories about salutogenesis ('health creation') and research showing the importance of health and social capital demonstrate the potential of this idea, and were combined with the health visiting study to create a theoretical framework for analytical purposes. Semi-structured interviews with the main carer in 50 families with resident children were analysed using this framework, to provide a lay perspective on how people consider they maintain their health. The analysis demonstrated the usefulness of treating health as a process and of focusing on the development of health-related resources rather than only on presenting problems. The processes of developing capacity were shown to be more important than the presence or absence of specific resources. Links with personal empowerment were apparent; cultural patterns that evolved across generations and neighbourhoods revealed possible pathways to social cohesion. Practice approaches that enhance or inhibit the development of these health-creating resources were identified, and considered in the light of emerging public health needs.

Keywords: salutogenesis, social cohesion, social capital, health capital, health visiting, public health, health promotion, health needs, lay perspective, empowerment

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INTRODUCTION

Health visitors are public health workers who are concerned with promoting health to a well population, most often to families with resident preschool children. However, financial constraints within the British National Health Service (NHS) are leading to pressure on health visitors to become more involved with people who display established clinical disorders or, at the very least, a demonstrable risk of developing a specified illness. This pressure is linked with the drive to achieve clinical effectiveness and a paucity of theoretical explanations against which to assess interventions designed to promote health, except in relation to prevention of specific diseases.

This paper revisits a grounded theory study that revealed an approach to health promotion and needs assessment that differs widely from the illness orientation prevalent within the NHS (Cowley 1995a). The study revealed how, in the absence of a need for clinical intervention, health visitors appear to assess needs by treating health as a process fuelled by the accumulation and use of 'resources for health'. That study will be set in the context of other, broader theories that demonstrate the potential of this idea and add to the critique of policies that treat health as if it were a variation on the theme of disease. These studies were combined into a theoretical framework used to analyse data drawn from 50 families with resident children, to provide a lay perspective to inform health visiting assessments and contracts. The method and results will be detailed and set in the context of public health concerns about increasing inequalities and rising numbers of disadvantaged groups in the UK.

SITUATION AND PROCESS

The research carried out by Cowley (1991, 1995a,b) followed a recent trend in which grounded theory has been used to uncover the hidden processes and features embedded within health visiting practice (e.g. Pearson 1991, Chalmers 1992, 1994, de la Cuesta 1993, 1994). Grounded theory is a strategy for handling data in research when little is known about the field of study (Glaser & Strauss 1967, Glaser 1978). Following the tenets of theoretical sampling, data were drawn from 53 practising health visitors and subjected to a constant comparative analysis to examine the processes involved in choosing which particular approach to use in any particular situation encountered in their work. The analysis suggested that, by treating health as a process, health visitors could integrate a number of competing and alternative views and beliefs about health into a single framework upon which to base their practice.

Health as process

The idea of health as a process is entirely abstract; it is not observable, but it can be conceptualized. The concept was not consciously expressed in the data, but the idea recurred throughout the health visitors' descriptions of their practice and perceptions of health. An international review of health promotion practices and concepts identified that health may be viewed in one of three ways (Anderson 1984). In the traditional medical formulation health is viewed as a 'product', bound up with notions of disease. It may also be viewed as 'potential'; Seedhouse (1986) is perhaps most often associated with the idea that positive health is a means by which opportunities of life can be realized. The idea of health as a process is third concept identified by Anderson. This concept of health emphasizes:

> …an ever changing, dynamic phenomenon or process…(which)… may relate to optimum physical growth and body development. The health process may be cumulative in relation, for example, to learning and development or cyclical in phases of creation and destruction. The point appears to be that health is a continuing pattern of change occurring over the lifetime in all dimensions of the individual (Anderson 1984, p. 61).

Although this is similar to the idea of health as potential, a key difference lies in the fact that 'processes' require context and meaning to make sense of them — so linkages, patterns, interconnections and actions are emphasized more than separate factors or events. If health is viewed as a process, it is not possible to conceive of any aspect of it that can stand alone, or be under the control of anyone other than the people whose health is under discussion; the whole socio-cultural context is important. The study suggested that health visitors largely direct their attention at the processes and associated context, rather than only focusing on the states of illness or wellbeing.

The grounded theory offers a hypothetical explanation for transition or change in the process in terms of the accumulation and use of 'resources for health'. These resources were not specified in any depth in the analysis, as no data were drawn from clients themselves. They appeared personal and situational, rather than being specifically limited to consumer items or financial means, although such resources as good housing and adequate income are clearly important to health. Resources for health appeared infinitely variable, being potentially internalized, individual and personal, or external to the person but arising from the situation in which they lived. Personal examples included emotional resources such as self-esteem, sense of trust in self and others (perhaps a partner or family), physical stamina or the cognitive ability to learn how to cope with a new baby. The postulated external resources might arise from the local environment, community, extended family and cultural influences at a wider level, or be drawn from formally provided services.

Health visitors need to identify which practice approach would be suitable in any particular situation and two aspects are of particular relevance to this paper. First, the work situation often appeared to constrain these health visitors into giving priority to professionally defined, normative needs. It was commonly recognised that lay perspectives could be more appropriate and useful in defining the needs to be targeted, and a number of practitioners claimed they deferred to these views in private while presenting a 'public face' of using the professionally accepted terminology and targets when reporting to their managers.

Secondly, the health visitors sometimes directed activities at improving the situation in which their clients lived — the position of the target group — rather than only focusing on presenting problems. Often, problem-focused work would target individuals, while activities directed at changing their situation were more likely to be linked to groups, communities or service provision. This is an unusual choice in health work; most professional roles are directed either at individuals or at groups, not usually at both. The study suggested that one of the key skills of health visiting is an ability to work confidently across the various different boundaries between lay and professional spheres, and between individually focused and community wide perspectives.

While this grounded theory offered a tentative explanation and framework that might guide health visiting practice, two aspects required further investigation. First, the theory does not, in itself, provide a basis for explaining how health is created; it only explains how health visitors treat health — an approach which may or may not be justified. Secondly, there was no information drawn directly from the client group being served. These omissions offer a fruitful starting point for further investigation. Two key areas of research that provide some justification for a health visiting focus on context and resources in pursuit of health will be outlined, before moving on to the lay perspective gleaned through a further research study.

SALUTOGENESIS

There is a view enshrined in medical science that all disorders have a specific cause; indeed, much medical research is directed at determining which factor causes a particular disease (Neihoff & Schneider 1993). That is the science of pathogenesis; a view that can be used to suppose that health is best promoted by identifying and preventing determinants of disease, rather than taking into account individual healing processes. Salutogenesis takes the opposite stance, stressing the importance of starting from a consideration of how health is created and maintained, rather than focusing on the negative aspects of illness and disorder.

Sense of coherence

The idea of salutogenesis is drawn from the philosophy and research of Antonovsky (1987, 1993), whose robust descriptions of health as a 'sense of coherence' provide a theoretical basis for explaining how health may be created. Antonovsky proposed that life experiences produce 'generalised resistance resources', which are positive ways of responding and adapting to situations. These resources promote the development and maintenance of a strong 'sense of coherence', which is synonymous with health. It is described as the extent to which one has pervasive, enduring and dynamic feeling of confidence that things will work out as well as can reasonably be expected; the theory is firmly located in the person's own context and culture.

Three central components of manageability, comprehensibility and meaningfulness are integral to the sense of coherence. The idea of manageability refers to the extent to which people feel they have the resources to meet demands that arise in their daily lives. It includes resources under direct individual control and those accessible from family, friends or the community. The concept depends quite closely on people experiencing a practical and physical sense of self-empowerment in coping with their own biology and threats to health. Comprehensibility refers to the extent to which sense and order can be drawn from the situation, and the world seems understandable, ordered, consistent and clear. In translating an exceptional experience such as illness, disability or unpleasant symptoms into the 'normal' context of their everyday lives, people make sense of what is happening to them and can gain strength to deal with the situation. The sense of meaningfulness a person can gain from a situation refers to their ability to fully participate in the processes shaping their future. To be fully engaged in the health creating processes of their own lives, people need to 'make sense' of events in an emotional as well as a cognitive sense. This means setting symptoms, experiences, treatments and coping mechanisms in the context of their own family, friends, personal contacts and reasons for living.

Health and social capital

The salutogenic model proposed by Antonovsky (1987) shows how health may be created at an individual level, and it is clearly based within a social rather than medical framework. Mechanisms by which this is translated into health across families or populations are less clear, but a growing literature suggests that social cohesion is an important determinant of health (Blane *et al.* 1996, Wilkinson 1996). Developed societies have mainly passed through an 'epidemiological transition' that marks the change from infectious disease as the biggest health hazard, to a situation in which most people die of

degenerative disorders (Wilkinson 1996). Traditionally, the accompanying increases in life expectancy have been attributed to economic gain and improvements in the physical environment, but this explanation fails to account for changes in population health once countries have passed through the epidemiological transition. Instead, Wilkinson suggests the psycho-social liberalization that accompanies economic development may be a major determinant of health, while inequalities across societies may, themselves, be a cause of disease.

The biological impact of absolute poverty is not questioned, but Wilkinson (1996) shows that the psycho-social and emotional stresses that accompany material insecurity and relative disadvantage are additional, major health hazards. Further, a growing number of studies about inequalities demonstrate that whatever it is that produces social gradients in health affects the whole of society, not just those people living in poverty (Mustard 1996). Thus, it becomes apparent that the psycho-social environment influences biological pathways that lead to health or to disease. Patterns of attachment within the family, across the life course and within one's particular society and culture all have a demonstrable impact on both the potential risk of disease and the potential for healing and health creation to be gained from autonomy and social cohesion (Rijke 1993, Fonagy 1996, Power *et al.* 1996).

The idea of 'social capital' refers to norms of reciprocity and networks of civic engagement that become embedded and enacted through moral resources such as trust and co-operation across the whole social system and not only by individuals (Putnam 1993). Mustard (1996) links this idea with 'health capital' by identifying forces that influence health across populations, such as socio-economic factors; childhood, competence and coping skills; and health service policies. This is essentially a salutogenic approach, since it focuses on activities that build and create health, rather than only focusing on the destructive forces of disease.

Targeting health in practice

The theories of salutogenesis, social cohesion and health and social capital provide a sound underpinning explanation of how health may be created, yet they offer no proposals about how these ideas could be taken forward in practice. Conversely, Cowley's (1991, 1995a) study showed that health visitors may already be treating health as a process and concentrating on the development and use of resources within a socio-cultural context.

This approach appears to be justified in the light of the emerging literature, and in the context of lost social cohesion and increasing inequalities in the United Kingdom (UK), now the cause for considerable political disquiet (Jowell 1997). However, a lay perspective on these matters was still required. An action research project aimed at enabling the delivery of a participative, 'needs-based' health visiting service in the context of general practitioner [GP] fundholding provided an opportunity to rectify this omission.

FAMILY HEALTH NEEDS

The Family Health Needs Project (Cowley & Billings 1997) set out to identify health needs of relevance to young families and to health promotion, then redirect health visiting practice to meet those needs. This paper reports only one aspect of the larger study, which combined Yin's (1994) case study approach with action research. Data were drawn through a purposeful sample of the main caretaker — mainly mothers — in 50 families by tape-recorded, semi-structured interviews, to elicit perceptions of health, health services and coping mechanisms. The families were all registered at a single general practice on the south coast. The sample was stratified to ensure that 30 families with preschool children and 20 with resident children aged between 5 and 18 years were included.

The interview guide was planned to elicit experiential and personal accounts of health. It focused primarily on obtaining qualitative data about health and wellbeing, but some structured data were collected for other purposes in the wider study. The interview therefore began with a self-administered questionnaire for the collection of quantitative data, then prompts and open questions were used to guide the tape-recorded interview. It was intended to elicit as many positive perceptions and explanations as possible about how people believe they maintain their health. Once the formal, structured part of the data collection was complete, the researcher deliberately adopted an informal, conversational style so as to engage the informants in talking naturally about their health-related perceptions and priorities.

Guba & Lincoln (1985) stress the importance of refining the skills of the 'researcher-as-instrument' in uncovering insights and detailed information about the phenomenon of interest. This open approach to interviewing depends on the ability of the researcher to be sensitive, responsive, empathetic, genuinely interested and apparently unshockable in listening to informants' stories; skills that were utilized to the full. The resultant data included a wide range of general and specific examples and perceptions of how the informants believed they maintained their own and their family's health.

Analysis

Yin (1994) emphasizes the notion of 'analytical generalization' rather than statistical generalization; this requires a previously developed theory to be used as a template against which to compare the empirical results of the case

study. An analytical framework was devised from the theories described above (Antonovsky 1987, Cowley 1995a). The interviews were all transcribed and coded using open and axial coding (Strauss 1987) to describe the substantive field from which the data were drawn.

Analysis proceeded by a process of simple pattern-matching, explanation-building and programme logic modelling within the case (Yin 1994). Patterns were sought, then matched across and between different segments of the transcripts, to discover potential themes and emergent logic in the data. Rival explanations may arise from the data; these are explored and integrated into the analysis and eventual findings. Thus, the initial framework is regarded as an hypothesis rather than a fixed entity, to be adapted and amended as the data are compared with it. Results are reported in a format that revisits these hypotheses and accepts or rejects them.

RESULTS

Resources for health

The beginning framework proposed a straightforward description of 'resources for health' derived from Cowley's (1995a) study. The first level of analysis set out to establish whether such resources were actually recognizable in the data, and if it was possible to distinguish between internal and external resources. Following Yin's (1994) pattern-matching technique, these initial propositions were compared with the data, the theoretical statements revised, then reapplied to the findings and further revisions made until the framework matched the data. As each theme was considered, its explanatory potential was assessed according to analytical robustness and incorporated into a refashioned theoretical framework supported by the data.

It proved easy to identify particular strengths, personal abilities, factors and features that were brought into play when a new need or demand arose; resources for health seemed almost universal, being present in some form in every interview. However, the postulated subdivisions and the distinction between 'internal resources' (personal physical, emotional, cognitive and social features) and 'external resources' (within the environment, wider family, culture and community) were more problematic.

It had been hypothesized that help from friends and extended families might be regarded as external resources, since they lay outside the individual person and their immediate, nuclear family situation. However, the data implied that the person's relationship and distance were less important than their acceptability, accessibility, familiarity and, importantly, the extent to which the informant felt able to maintain control over the advice, support and practical assistance that was available. This single parent, for example, lived several hours journey from her extended family but still described their help in quite a different light from that which needed to be sought from outside her personal circle:

> …but I think I find it difficult actually to ask for help at first. I, I'm very independent in that respect, I mean, I suppose it's in a way I've been brought up you sort of, you thought things out for yourself and if you had a problem the family were there, the family helped you…(47, 10).

'Being independent' was not synonymous with family help, either. Inevitably, personal history and circumstances affected the extent to which informants regarded family members as a helpful resource. Some close relatives who lived nearby or even resident partners were considered unable to offer health-related resources:

> I haven't got a very supportive partner so I think if you have, that makes life easier. I tend to think of myself as being more or less a single parent because I couldn't rely on him, um, in any way really. *Interviewer: The nature of his job is it, or just…* No, the nature of his personality, ha ha ha … So I tend to think of myself something similar along the lines of a single parent although I know I'm not and I haven't got the problems they've got but, um, yes, I don't think that — there are times when I get very down (11, 7).

Indeed, the negative and hurtful nature of some personal relationships implied they would be more likely to be pathogenic and harmful than salutogenic and able to contribute health-creating resources in a situation. Furthermore, as summarized in Table 1, identical practical, emotional and cultural factors could be described as either problematic or as a positive resource by different people. The distinction lay in the extent to which the informants were able to access or control them.

The postulated 'external resources' appeared mainly in the form of formally provided services; again the proposed framework needed to be revised. Resources that had been initially proposed as 'external' (e.g. in wider community, extended family) were easily recognized in the interview transcripts, but if they were useful and readily accessed, they seemed more accurately categorized as 'internal resources'. Thus, the whole idea of 'internal' and 'external' resources remained strong, but the distinctions between them were modified and extended.

In the refashioned framework, 'internalised resources' were distinguished by the extent to which they appeared familiar and under the control of the informants. This had little to do with geographical distance, kinship or the originally proposed categories; instead a sense of personal ownership and accessibility were all-important. Overall, the analysis implied that salutogenic processes involve developing a personal capacity for resourcefulness.

Exploring how resources became internalized for personal use, and the types of stressors that led to a demand for resources, shed some light on the mechanisms by which this capacity develops, as explained in the next section. The processes involved in gaining this sense of

Table 1 Resources for health

Resources identified in data	Pressures/demands for resources identified in data
Practical and physical environment • local environment/area: positive safe; good facilities for children; environment good: sea, countryside; good local facilities: schools; services • practical help and resources having enough money; family help financially; transport: own car, neighbours, family; space within home; time/opportunity to choose activities; network of friends or family for practical help; partner shares workload • physical abilities; practical skills energy and fitness; understanding benefits system; specific/professional skills • practical/coping ability good diet/food; managing money; family environment *Emotional and social situation* • self-esteem; inner strength positive childhood experiences; ability to accept situation; self-reliance; courage; maturity; tolerance; confidence; sense of humour; pride in environment; recognize small achievements • seeking meaning rationalizing/learning from experience; realizing self-worth; planning ahead; accepting: limiting illness or changed situations; staying positive against the odds; seeking choices; spirituality; religious beliefs; church = community • regenerating emotional resources being self-aware: of positive aspects/achievements; finding/sharing with other people; having a good marriage/partner; having friends and/or supportive family; knowing there is someone there; working = positive • resources derived from motherhood developing as a mother = developing as a person; accept/value responsibilities of motherhood; lone parenthood = no conflicting loyalties; pleasure from children/family; satisfaction; brilliant fun *Understanding and development* • personal/family culture pride in family values; reciprocal family support; learned from own upbringing and experience; expectations of self and children; well integrated into local area • learning and developing learning: specific knowledge; personal skills; seeking information; sharing/exchanging information with friends; formal services: learning how to get help; alternative therapies; different routes to 'finding out'; personal development to increase choices • coping strategies general: relaxing; being organized; time for self; adapting to change; seeking alternative options; related to parenting and family responsibilities	*Practical and physical environment* • local environment/area: negative run down area; lack of investment; crime; parks/streets unsafe; poor facilities; pollution • practical demands/pressures financial; public transport poor; housing unsuitable/problems; limited time/energy; no one to turn to for practical help • specific illnesses or disabilities physical and mental ill health: unmanagageable, enduring and/or unexplained symptoms; impaired activities of daily living [adults] or growth/development/learning [babies and children]; domestic violence; bullying • potentially negative coping strategies smoking; eating; alcohol *Emotional and social situation* • self-doubt and personal vulnerability personal history; difficulties in childhood; inability to seek help; guilt; embarrassed; courage needed [e.g. to disclose abuse] • personal outlook depressed about future; gloomy outlook; mental illness; depression; alcohol/drug abuse; no choice: 'just plod on'; 'stuck here'; 'put up with it'; lack of faith, e.g. in formal services/structures • emotional stresses family: not supportive; friction: family, neighbours etc.; domestic violence; feels alone/lonely; bereavement and loss; work pressure or unemployment • demands of motherhood motherhood = loss in confidence; sense of having 'lost self' and lost self-respect; pressures/expectations on mothers from society; sole responsibility = everything is difficult; children bring out the worst in you *Understanding and development* • culture clash/threats entrenched adverse attitudes in area; crime as norm; different family values/beliefs = criticism, pressure; poverty trap demotivates/offends beliefs; negative culture change, e.g. acceptance illicit activities like undeclared 'cash in hand' income • barriers to learning/developing stigma/shame = cannot seek help; embarrassed; unaware of learning needs: e.g. psychosis, drug misuse, intellectual impairment; situation = unclear, missed/uncertain diagnosis; personal dignity undermined; adverse and judgemental attitudes; racism • need for coping ability life events: positive and negative; reduced income; complicated benefits system; specific infant/child problems; specific adult disorders

personal ownership and control over necessary and needful resources for health show clear links with Antonovsky's (1987) sense of coherence and the concepts of meaningfulness, comprehensibility and manageability. As well, the process apparently reflects the widely recognized concept of 'personal empowerment' (Rappaport 1987, Zimmerman & Rappaport 1988).

Process of health

Unsurprisingly, no mention was made about health being regarded a process but, throughout, health tended to be portrayed as inseparably bound up with everyday living. A number of interviews were selected for a chronological 'mapping' of life experiences and program logic modelling, which is an approach that combines pattern matching with a time–series analysis (Yin 1994). This method was used to gain a greater understanding of how 'resources for health' are operationalized from the clients' perspective and to elicit information about the processes by which people create or maintain their health. The first level of analysis showed that the proposed distinction between 'internal' and 'external' resources was not fixed. This further analysis showed that the movement represented part of a dynamic process of developing a capacity for resourcefulness which extended over time, even through generations and across pre-determined boundaries.

One interview was focused around the impact of the informant's stressful relationship with her husband, and described vividly the physical and mental consequences of this. Despite her obvious unhappiness, she revealed examples of resources used to cope with this situation, resulting in the ability to continue and maintain apparently sound physical and mental health. The normal postnatal depression score (Cox *et al.* 1987) provides some indication of the success of her active manipulation, accumulation and use of resources for health that appear to counter some of the negativity. Motherhood, physical strength, satisfying employment, social and family support all seemed to combine to renew her ability carry on, and led to further opportunities to accumulate and generate salutogenic resources.

It had been hypothesized that 'health as a process' would be too abstract a concept to be revealed readily in the analysis. However, Table 2 represents these data, and shows this was not the case; the distinction between 'events' and 'processes' was readily identifiable. The middle column shows 'life events', while the outer columns show how the accumulation and use of resources illustrate the positive and negative processes affecting health. In other examples, negative life events included states of ill-health; life-changing or enduring disorders such as Cröhns disease, mental breakdowns or cancer, and disabilities following road traffic accidents were all mentioned. Positive examples included parenthood, marriage and changing careers. Whether positive or negative, such events were sufficiently significant to require translating into the person's self-identity or 'status'— as in being a single parent, or someone with a particular disability — so had an associated developmental need.

The process of learning and developing new ways of coping with different situations featured highly in the interviews. However, even if they were quite demanding at the time, events that were expected to be transient were barely mentioned in the data, except to explain the responses they drew from formal services, or the extent to which they enabled or encouraged personal development and learning. Indeed, the important issue appeared to be the process of internally assimilating, developing and recognizing the positive aspects and health-creating potential of the various practical, emotional or developmental resources, rather than exactly what the events or the resources were.

This capacity for resourcefulness and personal empowerment revealed cultural patterns that evolved across generations and neighbourhoods, showing possible pathways to social cohesion. Some informants derived support from and expressed a strong sense of responsibility towards family, neighbours or local area; others from a 'community' of friends or church, even if they lived at a distance. Having friends who were also coping on a low income created a comforting sense shared adversity, joint coping and reciprocity for this woman:

> it is on the surface quite a poor town, um, but everybody helps each other because you're on a limited income so um, you know, you can always go round to somebody's house um, for something to eat and they'll do the same and it will fluctuate. Um, you know, with clothes and um, equipment and all that sort of thing. All of these things sort of get passed around, you know (13, 9).

The relevance of such empathy and inside information in creating cultural expectations in an area was noted in several other interviews and situations. They illustrated how certain behaviours became or were reinforced as 'acceptable' and the positive potential of resources developed across wider areas. Such expectations may reflect an embedded reciprocity and indicate potential links between an individuals' sense of coherence and the social cohesion that occurs when a local environment is supportive and conducive to good health.

The most positive descriptions of coping processes appeared firmly orientated to the future, drawing resources generated in past situations and experiences to cope with present situations. Examples of long-established resources included anticipated family or social support, self-esteem and a positive conviction that a way forward could be found to deal with current problems. The future-orientation involved taking a clear responsibility for passing on social beliefs and behaviours to children, family members and across neighbourhoods.

Table 2 Accumulation and use of resources for health

Resources for health (positive processes)	Life events	Drains on resources (negative processes)
Support • close knit neighbourhood • supportive friend in similar circumstances • having a mother who was a single parent; who gave encouragement, confidence and acted as a driving force to recovery; who provided initial sanctuary and was always contactable 'I used to save up my 50ps to be able to phone her – then everything was OK again'. PS36:26. • other friends who would call, listen to problems and help with childcare • male friend who helped with maintenance of run-down house and gave moral support *Motherhood* • provided a reason in the early days to continue: 'I wasn't prepared for the love; the enjoyment, closeness and satisfaction of breast feeding put everything else out of my mind'. PS36:7	Deserted by husband when 3 months pregnant with first child Single parenthood	*Effects on mental health* • low self-esteem and morale: 'It just destroyed me…my mother had to pick up the pieces'. PS36:39 • stigmatizing effect of single parenthood; loss of confidence: 'you're just the scum of the earth'. PS36:24 *Complex nature of Benefits System* • militates against claiming full entitlement • staff unsympathetic and unsupportive: '…they make you feel you don't deserve it'. PS36:24 *Access to Health Services* • rendered difficult by lack of transport and money to pay fares
Support • shares problems and unhappiness with same friends and family as above • has a supportive, caring health visitor *Strength* • has universal sympathy and support, even from husband's family, which provides the physical strength to continue *Employment* • boosts self-esteem, control and independence • means of escaping, 'blocking out' unhappiness • finances driving lessons to further independence • mutual childcare helps *Motherhood* • has provided a purpose; love is channelled to children who give the reason to carry on	Reunited with husband three years later, but relationship poor (? still having an affair)	*Effect on mental health* • loss of confidence, self-esteem • loss of independence and control; has to ask for money and justify requests; restricts lifestyle • feels suffocated and dominated • constant rows are stressful; concerns for long-term effect upon children • lack of trust: 'I get anxious if he's late…who he's with'. PS36:38 • lack of support; husband avoids all parental responsibility: 'he acts like a single man'. PS36:34 • being unable to leave due to current level of dependence • being resigned to the situation and avoiding arguments as a way of coping: 'he's never going to change, I've just got to put up with him'. PS36:12 *Physical effects* • constant tiredness due to strain and lack of support in the home • poor sex life • smokes to counter effects *Lack of transport* • dependent upon other people due to poor bus service

Age 31–40, married, owner/occupier, s/c IIInm, both in employment (informant works part-time), two children aged 6 months and 6 years. Overall health rated as good. Post-natal Depression Score: 9 (not considered at risk).

Formal service provision

Having elicited direct information about processes by which people create or maintain their health, the last part of the analysis set out to identify aspects of the health creation process that could serve as critical periods for intervention by health visitors. The initial analytical framework postulated that such periods would be identifiable, but there was little in the data to indicate how beneficial periods for intervention might be identified, beyond the already clear need for prompt clinical assessments and treatment when a specified disorder or symp-

Table 3 Impairing or enhancing resources for health

Enhancing practical and physical abilities
- health visitors: good advice; helpful; baby clinics: good appointment system; homely; accessible; well organized
- GP practice: can always get an appointment
- GP: helps with symptoms; makes referrals; gets hospital appointments; responsive: waiting times improved recently; very good
- other services: good midwifery care; good institutional care/special school for handicapped children; Macmillan nurse
- alternative therapies: shiatsu; homeopathy; herbalism; psychotherapist; counsellor
- legal proceedings: police = good post-burglary support; environmental health officer; social worker helpful; solicitor/legal advice
- Housing association responsible for structural repairs; rehoused dispossessed family

Impairing practical and physical abilities
- health visitors: hard to access; not helpful; too busy; service cut back; clinics cold, dreary
- GP practice: refused to give appointment; receptionists 'incredibly rude'; obstructive
- GP = reluctant to refer since became a fundholder; things have changed; fundholding = 'not NHS'; receptionists decide prescription, not GP
- hospital experience: consultant unhelpful; long waiting list; services not available locally; discharged too soon – not fit; wrong treatment; unhelpful treatment; misdiagnosis; delayed diagnosis; community care services not available; needs of carers not taken into account
- benefits system: inadequate; does not allow for individual needs; restricts ability to work;
- police: unhelpful in domestic violence
- housing: unsuitable, e.g. dampness unhealthy, increases heating costs; temporary housing

Enhancing emotional and social situation
- health visitors: wonderful; brilliant; excellent; a real friend; can trust them; reassuring; supportive; feel listened to; like home visiting service: like a friend visiting; prompt visits when needed; clinic = good social atmosphere
- GP: listens, doesn't make you feel a nuisance; listens because you're the Mum; marvellous; really nice; always there for you; like a Dad; lovely to children; brilliant; GP practice: all very caring; rural surgery = relaxed atmosphere
- mental health: counsellor helps, psychiatrist; anti-depressants; child psychiatrist is lovely; community psychiatric nurse helpful; the therapist; family therapist; family centre

Impairing emotional and social situation
- health visitors: constant changes = cannot get to know them; unaware of extent of problem; are 'not bothered'; 'not part of my life' clinics = clinical and unwelcoming; 'cattle-market'/'conveyor belt' approach; no privacy; only for weighing, not a chat
- GP = blaming attitude; blames everything on stress; treats you like a nuisance; does not listen; disappointed recently; town centre surgery: atmosphere very stressed
- hospital experience: unhappy; cold and clinical; impersonal; distressing; uncertainty and waiting for diagnosis/tests/results stressful
- stigma: personal dignity compromised, e.g. by benefits system/requirements; by 'handouts' for disadvantaged children; no choice about where housed; privacy infringed
- benefit system: blaming attitude of staff; punitive; like begging

Enhancing understanding and development
- health visitors: 'work in consultation with parents'
- doctors/nurses/health visitors: explain situation; advice; information about specific issues/problems; changing GP is easy
- self-help and support groups
- adult education facilities for personal development
- good facilities for children, e.g. schools; nursery; mother and toddler/playgroup

Impairing understanding and development
- health visitors: developmental checks = unnecessary worry; conflicting advice at clinic; stop visiting too soon; being left to own devices
- GP does not take worries seriously; makes you feel stupid; does not explain; likes HV but not GP = will not change GP, to keep HV
- hospital: inadequate/unhelpful advice; unprepared for hysterectomy; do not explain
- benefits system: complicated; difficult to understand; promotes 'cash in hand' culture

tom is present. However, numerous factors that affected the salutogenic processes were revealed (Table 3).

The personal style and attitude of health professionals were, above all, important in either enhancing or inhibiting salutogenesis. If tentative requests for help or expressions of concern are belittled or negated, for example, the opportunity for people to develop or generate their own resources in conjunction with health care professionals may be subverted into coping with the additional stresses created by such adverse attitudes. Some informants experienced services that were so inflexible or individually ineffective, that trying to find a way around the convolutions and bureaucracy became a stress that created a demand for resources in addition to

(and possibly even greater than) the original need. In such situations, the capacity for generating resources and developing individual, family or community wide support networks were inhibited rather than enhanced by the formal service provision.

Often, support and help of equal, or greater, value could be readily obtained from within the clients own network, but there were two risks associated with this. In a minority of cases, such support perpetuated and added to the 'social acceptability' of coping mechanisms known to have an adverse effect on health. Smoking was the most commonly mentioned, but other examples included the use of illicit drugs, adding alcoholic spirits to a baby's bottle as a pacifier, domestic violence and potentially over-harsh disciplinary measures. Strategies with a wider potential impact included self-imposed social exclusion as a mechanism for coping with crime, 'cash-in-hand' as a way of ameliorating poverty and use of emergency health services instead of primary care provision. The further danger associated with this risk is that adverse and anti-social behaviours may become entrenched as local cultural norm, leading to a loss of social cohesion and sense of civic community (Putnam 1993).

The second major risk concerns the most vulnerable people, who had the least obvious networks of support upon which to call. The interviews revealed that these individuals often faced the 'double jeopardy' of having limited access to reliable and positive resources in their personal situation, but the immediate availability of both demanding stressors and plentiful inappropriate advice-often to engage in the kinds of potentially dangerous behaviours described above.

Special skills are clearly needed to enable such disadvantaged people to both develop resources and strategies for coping that are not potentially harmful to either themselves as individuals, or the wider community in which they live; while at the same time enabling them to feel valued and in control of their own lives and health. The need to generate health and social resources in the situation within which these people live adds to discussions about whether the main focus of health visiting approaches should be on the presenting problem (the 'event') or the wider situation (the position) in which people find themselves. The significance of approaches that enable development of situational resources through facilitating, listening and providing a timely and reliable source of support should not be underestimated.

DISCUSSION

There are two pressing influences upon contemporary health visiting practice, that stem from the wider situation of the economic situation and public health of the UK population. Awareness of a limited public purse has led to restrictions on the funding base for the NHS; this looks set to continue under the new Labour government elected in 1997. The former administration required health authorities or GP fundholders (who held the purse strings) to assess the health needs of the population they serve, and establish contracts with health service providers — mainly hospital and community trusts — to meet those identified needs. Proposed legislation (Department of Health 1997) will dismantle this internal market, but the principle remains that strategic plans for services, to be known as 'Health Improvement Programmes', will be drawn up following an assessment of the health needs of the population.

Despite this legislative emphasis, policy does not specify what counts as a 'health need' nor how it should be defined. This has led to considerable debate; one much-cited definition that captured the spirit of the NHS and Community Care Act 1990 suggested that 'need is the ability to benefit from care' (Stevens & Gabbay 1991). Since the well population is construed as having no potential to benefit from clinical interventions, it is increasingly assumed they have no general need for a health promoting service, and therefore no need for health visiting on a regular or routine basis (National Health Service Executive 1996). Despite increasing evidence of their effectiveness (e.g. Botes *et al.* 1997, Community Practitioners' and Health Visitors' Association 1997), health visiting services nationwide are facing considerable reductions in their numbers and funding (News 1998).

In tandem with this reduction, there is rising concern about the state of public health in the UK, evidenced by increasing inequalities in health, social exclusion, rising crime and a costly increase in ill-health among numerous vulnerable groups (Benzeval *et al.* 1995, Lawson 1997). A new minister has been appointed with a special responsibility for public health and has expressed a determination to improve these matters, by focusing attention upon enhancing the capacity of such individuals and communities to take control of their own health (DoH 1998, Jowell 1997). However, there is no specific public health budget, and the determination of the NHS to continue to concentrate upon illness rather than health appears undiminished.

This paper has argued that the health visiting approach of treating health as a process and concentrating on the development and use of resources in a socio-cultural context is justified by recent research, emerging literature, and in the context of diminishing social cohesion and increasing inequalities in the UK. The lay perspective elicited in this study provides further support, showing cross-generational and community-wide links that testify to the potential of the health creating processes and resources if they can be harnessed. Further research would be needed to assess outcomes across the populations served, to demonstrate whether health visiting is effective in developing this potential or not.

However, if funding pressures and the prevalent 'illness perspective' within the NHS continue to minimize awareness of factors that contribute to health, the public health endeavours of this professional group are likely to be further marginalized. More importantly, the pathogenic descent of their client population into increasing social exclusion, widening health inequalities and lost potential seem set to continue, so attempts to check or reverse the decline are urgently required.

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