CHAPTER 3

COPING AND SALUTOGENESIS

3.1 COPING

3.1.1 INTRODUCTION

Individuals are often faced with numerous problems and challenges throughout their lives. These problems and challenges are sometimes referred to as stressors, and they range from everyday difficulties to major crises. Such experiences can not only cause emotional stress, but can also have long-term cumulative effects on physical and psychological health.

Researchers have collected a wealth of information about how people cope with challenges and problems. They have directed their efforts toward answering questions about whether different styles of coping can be identified, whether some coping strategies are more useful for certain problems than others, and how can people learn to cope more effectively with challenges that confront them (Kleinke, 1991).

Before one can embark on the study of coping with stressors, it is imperative that we look at the concept of stress. Hopfoll (cited in Bogle, 1995) describes stress as one of the most complicated phenomena. It involves various systems of the body – cardiovascular, endocrine and neurological; the systems of the psyche – cognitive, emotional and unconscious; and occurs in all social systems - interpersonal, small and large groups. Stress is evoked by such varied stimuli as minor daily hassles, or major life threatening events. It involves our loves, hates, closest attachments, competition, achievements, and every matter in which humans are involved.

According to the biological model of stress that centres on the general adaptation syndrome as formulated by Selye (in Fleming, Baum & Singer, 1984; Monat & Lazarus, 1977), there is a three-stage process that describes how stress affects the individual. The first stage of the process is alarm, in

which the organism is mobilised to combat the physical demands of the stressor. The second stage is resistance, in which the organism tries to deal with the still present threat. The third stage is exhaustion, which is brought upon by prolonged exposure to a stressor without resolution. Though there may be no immediate obvious change in environmental conditions, the organism seemingly gives up, and the collapse may result in death. Presumably this only occurs when the threat persists or repeats often enough to overwhelm the organism's ability to resist. The implication of this model is that the effects of stress are cumulative and are involved in serious pathology when they overwhelm one's ability to resist. Stress is not regarded as an environmental demand (which Selye called a stressor), but a universal physiological set of reactions and processes created by such a demand (Lazarus & Folkman, 1984).

The psychosocial model of stress views stress as the reaction of an organism to demands placed upon it. The key focus within this model is upon healthy, usually normal humans and non-physical stressors. The emphasis is on the interaction of stressful agents and the human system of appraisal and evaluation. In this model, stress is conceptualized as a process that involves recognition of and response to threat or danger. Coping, a central part of this process, includes overt and covert responses to threat or danger, usually directed toward overall reduction of stress (Fleming *et al.*, 1984).

3.1.2 THE CONCEPT OF COPING

Historically, coping has been viewed primarily as a response to emotion and was defined as learned behaviour that contributes to survival in the face of life-threatening dangers. These behaviours are initiated by fear, which motivates the behavioural response of avoidance or escape, and by anger, which motivates confrontation or attack (Folkman & Lazarus, 1988).

Within the ego-psychology model, coping includes cognitive processes, such as denial, repression, suppression, and intellectualisation, as well as problem-

solving behaviours, that are used to reduce or manage anxiety and other distressing emotional states (Park, 1998).

Moran (1994) states that much has been written on coping, and sometimes the term is used interchangeably with terms like adaptation, mastery and defence. Billings and Moos (cited in Moran, 1994) argue that in many early definitions, coping tended to be viewed as the intrapsychic processes with which a person protects his or her emotional functioning from threat. They go further to suggest that this approach tends to limit the concept of coping to intrapsychic efforts to maintain psychological equilibrium, without taking into account the overt behaviour aimed at solving the problem or at avoiding the threat.

As suggested by Snyder and Ford (1987), the effort at coping should not be required by definition to imply success in protecting people from harm. They propose that any attempt to protect, whether or not it succeeds, should be defined as coping behaviour. Snyder and Ford (1987) therefore define coping as a response whose purpose it is to reduce or avoid psychological stress, pointing out that this definition does not necessitate success in reducing the stress, but is just an attempt to do so.

The literature on coping is quite extensive and has examined a variety of stressful experiences. As reviewed by Lazarus (in Marco, Neale, Schwartz, Shiffman & Stone, 1999) the literature indicates several consistent findings:

1. Coping depends on appraisal of whether anything can be done. If something can be done, then problem-focused coping predominates; if nothing can be done, then emotion-focused coping predominates.
2. Coping acts as a mediator of emotional outcomes.
3. Coping efficacy varies with the type of stressful encounter, the type of personality, and the outcome modality studied.

Folkman and Lazarus (1980) were critical of coping models that focused only on defence mechanisms, intrapsychic processes, and some small segments

of the full range of behaviour in the coping process. They asserted that a coping model is not complete if it does not include the many forms of overt actions which people resort to in response to a challenge or threat to their well-being. Lazarus and his colleagues went on to produce such a model, which turned out to be one of the most comprehensive models available.

3.1.3 THE COGNITIVE PHENOMENOLOGICAL MODEL OF COPING

The model is based on the cognitive theory of stress and coping. The theory is said to be transactional in that the person and the environment are viewed as being in a dynamic, mutually reciprocal, bi-directional relationship. Stress is conceptualised as a relationship between the person and the environment that is appraised by the person as taxing or exceeding his or her resources and as endangering well-being (Folkman, Lazarus, Gruen & DeLongis, 1986). Folkman (1984) emphasises the fact that in the definition offered above, stress is not a property of the person or the environment, nor is it a stimulus or a response.

The theory identifies two processes, cognitive appraisal and coping, as important mediators of stressful person-environment relationships and their immediate and long-term outcomes (Folkman *et al.*, 1986a).

3.1.3.1 Cognitive Appraisal

Cognitive appraisal is a process through which the person evaluates whether a particular encounter with the environment is relevant to his or her well-being and, if so, in what way. There are two types of cognitive appraisal: primary and secondary.

> ***Primary appraisals** refer to judgements that a transaction is irrelevant, benign-positive, or stressful. An appraisal that a transaction is irrelevant is a judgement that it has no significant for well-being, and a benign-positive appraisal indicates that a transaction does not tax or exceed the person's resources (Folkman, 1984). Here a person

evaluates whether he or she has anything at stake in the encounter. Examples of this will be assessing whether the situation posseses potential harm to self-esteem, or whether the health of loved ones is at risk or not (Folkman *et al.*, 1986a).

Folkman (1984) identifies three primary appraisals, namely harm/loss, threat and challenge. Harm/loss refers to injury or damage already done, as in loss of a limb. Threat refers to potential harm or loss, and challenge to an opportunity for growth, mastery, or gain. McCrae (1984) states that challenges differ from threats in their generally positive tone, although, like any stressor, they require exceptional efforts from the individual. Challenges are also perceived as being often controllable. Challenges and threats are likely to be chronic, whereas losses tend to be acute stressors.

A primary appraisal is shaped by person factors such as beliefs and commitments; as well as situational factors such the nature of the event, whether the event is familiar or not, how is it likely to occur, when is it likely to occur, and how clear or ambiguous the expected outcome is (Folkman, 1984).

***In secondary appraisal** the person evaluates coping resources and options, addressing the question "what can I do?" (Folkman & Lazarus, 1985). Coping resources, which include physical, social, psychological, and material assets, are evaluated with respect to the demands of the situation. Examples of physical resources are the person's health, energy, and stamina, while social resources represent the individual's social network and support systems, from which an individual can draw information, assistance and emotional support. Psychological support resources include beliefs that can be drawn upon to sustain hope, skills for problem solving, self-esteem, and morale. Material resources refer to things like money, tools and equipment (Folkman, 1984). The link between these resources and

Antonovsky's General Resistance Resources (GRRs) will be discussed in 3.2.4.

Folkman and Lazarus (1985) perceive the primary and secondary appraisals as working interdependently. For example, if coping resources are adequate for dealing with a threat, the degree of threat is diminished. On the other hand, an event that at first might seem non-threatening can become threatening if coping resources turn out to be inadequate for countering environmental or personal constraints.

3.1.3.2 Coping

According to the theory, coping is seen as the person's cognitive and behavioural efforts to manage, reduce, minimise, master, or tolerate the internal and external demands of the person-environment transaction that is appraised as taxing or exceeding the person's resources (Folkman, 1984; Folkman & Lazarus, 1985; Folkman, *et al.*, 1986a).

Folkman, Lazarus, Dunkel-Schetter, DeLongis and Gruen (1986) identify three features of this definition.

- It is process oriented, meaning that it focuses on what the person actually thinks and how he/she behaves in a specific stressful encounter, and how this changes as the encounter unfolds. Observations and assessments are concerned with what the person actually thinks or does, in contrast to what the person usually does, would do, or should do, which is the concern of a trait approach. The trait approach thus places emphasis on stability rather than change.
- They view coping as contextual, that is, it is influenced by the person's appraisal of the actual demands in the encounter and the resources for managing them. This means that the person and situation variables together shape coping efforts.

- Coping is defined independently of its outcome. It refers to efforts to manage demands, regardless of success of those efforts. Therefore, there is nothing like good or bad coping.

3.1.3.3 Functions of Coping

In this model, coping is viewed as having two major functions, namely, to regulate the emotions or distress and to manage the problem that is causing distress. These functions are also referred to as emotion-focused and problem-focused forms of coping respectively (Folkman, 1984). Both forms of coping are used in most stressful encounters and the relative proportion of each form varies according to how the encounter is appraised.

Examples of problem-focused coping include behaviours like getting a person to change his or her mind, making a plan of action and following it, fighting for what one believes in or wants. The emotion-focused strategies include behaviours such as looking on the brighter side of things, accepting sympathy and understanding from someone, and trying to forget about the problem. Problem-focused coping is found to be mostly used in situations that were appraised as changeable, thereby holding the potential for control, and the emotion-focused form of coping is used in situations that are appraised as not changeable (Folkman & Lazarus, 1985).

3.1.3.4 Coping and Emotions

Much of the research on the relationship between emotions and coping in humans has focused on the ways in which emotion, in the form of anxiety, can interfere with cognitive functioning and hence coping (e.g., Krohne & Laux; Schwarzer & Spielberger, as noted in Folkman & Lazarus, 1988). This research has been criticised by Folkman and Lazarus (1988) for failing to take into account the complexity of emotion and coping processes, when treating emotions as undimensional drives. Here emotions are just seen as affecting coping both by motivating it and impeding it in a unidirectional causal pattern. However, the relationship between emotions and coping in a stressful

encounter is bi-directional, with each affecting the other. First, the transaction is appraised as harmful, beneficial, threatening, or challenging. The appraisal of the situation then generates emotions, and the two influence the coping process, which in turn change the person-environment relationship. The altered person-environment relationship is reappraised, and the reappraisal leads to a change in emotion quality and intensity. In this way, coping is a mediator of the emotional response (Folkman & Lazarus, 1988).

Emotions depend on the cognitive appraisals of the significance of the person-environment relationship for the individual's well-being and the available options for coping (Folkman & Lazarus, 1988). Folkman (1984) pointed out that harm/loss and threat appraisals are often characterised by negative emotions, such as anger, fear, or resentment, whereas challenge appraisals are characterised by pleasurable emotions, such as excitement and eagerness.

Emotion-focused coping is mostly used to control distressing emotions, sometimes by altering the meaning of an outcome. The effectiveness of problem-focused coping is said to depend on the success of emotion-focused efforts. If this were not the case, heightened emotions would interfere with the cognitive activity necessary for problem-focused coping (Folkman *et al.*, 1986b).

3.1.3.5 Personal Control and Coping

Among the beliefs that influence primary appraisal, are what Folkman (1984) refers to as generalised beliefs about control. These beliefs have their greatest influence when the situation is regarded as ambiguous or novel. When conditions lack clarity (ambiguous), situational cues regarding the nature of the outcome and/or the extent to which the situation can be controlled are minimal. Under such highly ambiguous situations, a person with an internal locus of control, who has the conviction that events are contingent upon one's own behaviour, might appraise it as controllable. When the situation is not highly ambiguous, it is often expected that

judgements about controllability would be influenced more by situational characteristics than by generalised beliefs.

According to Folkman (1984), threat and challenge appraisals, which influence coping, are affected by control appraisals. Threat appraisals seem likely when the desire for control is not matched by expectations for control or when the exercise of control can generate additional distress. On the other hand, challenge appraisals seem likely when encounters that are appraised as relevant to well-being hold a potential for control, and the exercise of control creates little additional distress.

Appraisals of control can shift as an encounter unfolds. Changes in appraisals of control can come about as a result of new information from the environment and coping efforts (Folkman *et al.*,1986a). In real life, control appraisals are viewed as complex, especially in health related contexts. Cohen and Lazarus (in Folkman, 1984) cited the following coping tasks in recovery from illness, each of which refers to an outcome or target of control:

1. To reduce harmful environmental conditions and enhance prospects of recovery.
2. To tolerate or adjust to negative events and realities.
3. To maintain a positive self image.
4. To maintain emotional equilibrium.
5. To continue satisfying relationships with others.

Most research on the relationship between control and stress is based on the assumption that having control is stress reducing and not having control is stress inducing, but Folkman and Lazarus (1985) indicated that the opposite is sometimes true. The way events are connected in real life seems to be the reason behind this observation. An example they give is that of a patient who is told that there is potential for controlling his or her malignancy through chemotherapy. Having chemotherapy may result in malignancy being contained, but at additional cost to the patient's physical and psychological well-being (such as nausea, hair loss, and depression).

Strickland (in Aldwin 1994) pointed out the relationship between control and the type of coping activity. She noted that people with internal locus of control are more likely than people with external locus of control to engage in an information search about disease and health maintenance when it is relevant to their well being. They are also more likely to use more problem-focused behaviours and less emotion-focused behaviour than those with external locus of control are.

Sometimes an experience can be perceived as not reinforcing internal control beliefs. Under such circumstances, an illusion of control can be created through cognitive coping or reappraisal. This can be noticed in a situation where a person takes on responsibility or blame for an event, regardless of the circumstances. Such a reappraisal can make that person to believe that similar events can be prevented in the future, thereby enabling him/her to feel more in control of future events and less threatened (Aldwin, 1994).

3.1.4 PERSONALITY AND COPING

Although the transactional theory of coping holds that the situational appraisals are the key determinants of the coping efforts, another perspective maintains that personality dispositions are also important determinants of coping because they predispose people to use certain coping strategies (Gunther, Cohen & Armeli, 1999). The five-factor model of personality is usually used to look at the relationship between coping and personality since it provides a useful context for assessing individual differences in coping strategy used.

The Big Five is described as a taxonomy of broad, higher order personality dimensions thought to represent the minimum number of traits necessary for adequately describing personality. It includes Neuroticism, Extraversion, Openness to experience, Agreeableness, and Conscientiousness (N, E, O, A, and C, respectively). People high in N are said to normally experience negative emotions such as depression, anxiety, and anger. They are also likely to appraise stressful situations as threats rather than challenges.

Extraverts tend to be energetic and cheerful, and tend to view stressful situations as challenges. People high in O are thought to be untraditional and imaginative, and they are believed to appreciate aesthetic experiences. More agreeable people are likely to be characterised as helpful, trusting, and straightforward, whereas those high in C seem reliable, hardworking, and self-disciplined (Gunther *et al.*, 1999).

David and Suls (1999) noted some links between some of these traits and use of certain coping strategies. People who score high on E should rely more on active, problem-focused coping strategies because of their tendency to see problems as challenges, whereas those high in N should rely more on passive or emotion-focused strategies due to their tendency to interpret problems as threats rather than as challenges. The above expectations were found to be consistent with reports that demonstrated that people scoring higher on N have shown a tendency to rely more on emotion-focused coping strategies and less on problem-focused strategies.

In studies conducted by McCrae and Costa (1986), and Watson and Hubbard (1996) relationships were found between personality traits and coping strategies used. N was found to relate positively to wishful thinking, self-blame and seeking emotional support. People who score high in E were found to be more likely to take action, engage in positive thinking, seek social support and employ more problem-focused coping in general. These people were also associated with less use of emotion-focused coping and avoidance.

Openness to experience related positively to positive reappraisal and use of humour and negatively to use of religious faith as a coping strategy. Active coping and planning, support-seeking, and positive reappraisal are also related positively to A. People with higher C scores tend to use more problem-focused coping strategies like active coping, planning, suppression of competing activities, and restraint coping. These people also engage in less emotion-focused coping like drugs, alcohol, denial and accepting responsibility.

Although consistent trends have emerged, David and Suls (1999) pointed out several limitations in the above findings. The majority of studies have been cross-sectional in nature and required participants to recall coping efforts used in the past week, month or more. Reports of coping responses may be subject to memory biases and reflect long term personality dispositions as the time interval between coping efforts and the coping assessment increases. The association between personality and coping may be inflated in such studies. David and Suls (1999) suggest that more accurate reports on this subject can be obtained if the coping strategy used is measured soon after the stressful episode.

3.1.5 COPING WITH HIV

There seems to be a great deal of interest in the possibility that psychosocial factors, and in particular stressful life experiences, psychological distress, and coping resources, are capable of altering the course of HIV-infection by influencing immune functions. The documented association between chronic stress and suppression of immune functions is used as a basis for suspecting that stress and coping might affect the course of HIV infection (Vassend & Eskild, 1998).

Among factors that may serve to buffer the impact of HIV on those infected, coping is considered to be an important factor affecting adaptational outcomes such as psychological well-being, especially in the long term (Lazarus & Folkman, 1984).

Moneyham, Hennessy, Sowell, Demi, Seals and Mizuno (1998) are of the opinion that the choice and effectiveness of the coping strategies used in stressful situations such as illness, should vary over time as a function of changes in the contextual factors like the stage of the disease and related physical symptoms.

Active problem focused coping is found to be effective in some situations and not in others. Although there is some evidence that passive coping strategies,

such as avoidance, are associated with positive adaptational outcomes when dealing with short-term stressful situations, their use appears to be less effective over the long term. The use of avoidance coping strategies was mostly found to be associated with increased psychological distress including anxiety, depression and poor adjustment. There is also a possibility that the relationship between avoidance coping and psychological distress is a function of the stage of the disease, since there were instances where avoidance coping was found to be related to positive outcomes (Moneyham *et al.*, 1998).

Although strategies used by women to cope with HIV are likely to differ in different populations and in different situations, studies have found that emotion-focused coping strategies like spirituality or seeking social support, to be positively associated with the psychological well-being of women with HIV (Bennetts *et al.*, 1999).

Most of the research done on coping with HIV has been focusing on the relationship between coping and the adaptational outcomes. The shortcoming of such research is that it fails to consider the role of the context in which coping occurs, and thereby limits the understanding of responses to difficult situations such as illness (Pedersen & Elklit, 1998).

An example is noted by Springer (cited in Moneyham *et al.*, 1998), that the great majority of women infected with HIV are usually poor, from minority groups, and must focus most of their energy on the daily quest of meeting the survival needs of their children. Because of such factors, it has been suggested that women may be particularly vulnerable and unprepared to deal with the demands of HIV-infection due to deficits in the socio-economic resources that support effective coping. Another example is the notion that avoidance coping has been reported to be prevalent among women, minorities, and those with lower education and income. There is, however, little direct empirical evidence that supports the notion that HIV-infected women cope less effectively than other HIV-infected populations (Bennetts *et al.*, 1999).

3.1.6 SOCIAL SUPPORT

It is generally argued that people will fare better when faced with stressful life situations if they have social support (Kimberly & Serovich, 1996). According to Cobb (1976), social support incorporates three components: a) belief by the recipient that he/she is cared for and loved, b) belief by the recipient that he/she is valued, and c) belief by the recipient that he/she belongs to a network of communication and mutual obligation.

Caplan and Killilea (in Santelli, Turnbull, Lerner & Marquis, 1993) defined social support as the attachment among individuals or between individuals and groups which improves adaptive competence in dealing with short-term crises and life transitions as well as long-term challenges, provisions and stresses. This support is accessible to an individual through social ties to other individuals, groups and larger communities (Cobb, 1976). Shumaker and Brownwell (as cited in Zimet, Dahlem, Zimet & Farley, 1988) noted that social support can also be characterised as an exchange of resources between at least two individuals, perceived by the provider or the recipient to be intended to enhance the well-being of the recipient.

Social support is seen to operate as a stress buffer, which moderates the relationship between life events and psychological disorders. It can also be important in the response to both positively and negatively perceived stressors (Bogle, 1995).

Two broad approaches were identified in the assessment of social support. The structural approach looks at some aspects of the structure of the network of relationships. The functional approach, the most commonly used of the two, looks at aspects of the person's relationships, or the ability of those relationships to provide important support functions (Oxford, 1992).

According to Santelli *et al.* (1993), the type of support obtained through support networks varies. Instrumental support, which is sometimes referred to as material assistance, tangible support and aid, is the most common type

found. It refers to provision of services and goods that usually assist in solving practical problems. Such support includes things like providing loans and gifts of goods or money (Firth & Rapley, 1990).

Another function of support, which is perceived to form a significant part of social support, is emotional support. It includes listening, showing concern, conveying intimacy (Leavy in Oxford, 1992), warmth, love, caring trust and encouragement (Tolsdorf in Oxford, 1992), empathy and understanding (Santelli *et al.*, 1993). Other components of emotional support are intimacy, attachment, reassurance, and the ability to confide in and rely on one another (Schaefer, Coyne & Lazarus in Oakely, 1992). All the above contribute to a feeling of being part of the group, feeling loved, and cared for.

Thoits (1986) refers to cognitive-informational support, which is sometimes known as advice or guidance, as another function of social support. It basically includes provision of information and advice, which could assist a person in solving problems or giving feedback on how a person is managing his/her life (Schaefer in Oakley, 1992). Solano (in Fehr, 1996) is of the opinion that significant others in an individual's life provide him/her with a frame of reference which may be used to interpret the world and to find meaning in his/her experiences.

Providing company is also seen as another function of social support. Social companionship is defined as spending time with others in leisure and recreational activities. Such activities can be viewed as of help in reducing stress by fulfilling a need for affiliation and contact with others. This can further help in distracting persons from worrying about problems (Cohen & Wills, 1985).

Antonovsky (in Kobasa and Puccetti, 1983) refers to the general resistance resources (GRRs), namely cognitive and emotional, valuative-attitudinal and interpersonal-relational, which could be interpreted in terms of social support since they include the dimensions of understanding, caring and sharing. A lack of support in these dimensions leads to a general resistance deficit

(GRD) and increased levels of stress. A further discussion on the GRRs and GRDs will be given in 3.2.4 and 3.2.5.1.

Being part of a family and having friends does not necessarily mean that one is the automatic beneficiary of support in times of trouble. The degree at which people can draw upon social relations for support depends on more than either the extensiveness of the relations or the frequency of the interaction (Mitchell, Cronkite & Moos, 1984). Support, rather, comes when people's engagement with one another extends to a level of involvement and concern, as is true of family members and close friends, and not when they merely touch at the surface of each other's lives (Pearlin, Menaghan, Lieberman & Mullan, 1981).

Although the availability and provision of social support for people with HIV is perceived to be important (Pedersen & Elklit, 1998; Siegel, Karus, Raveis & Hagen, 1998), there is evidence to the fact that disclosing one's HIV status frequently results in ostracism from family and/or friends (Altman cited in Kimberly & Serovich, 1996). This leads to loss of support.

Because of the physical and psychological stresses on people with HIV, it is crucial for them to establish realistic expectations about who can and will provide support. Providers of support like family and friends may not be available for HIV positive people as for others seeking support because of fear or stigma (Sowell & Misener, 1997). Public opinions and attitudes towards those infected with HIV are based on negative stereotypes, which may lead family members and friends to withdraw support (Kimberly & Serovich, 1996).

Individuals seek social support because they need assistance. People infected with HIV seeking support must disclose their status in order to receive support. The problem comes when they have to decide as to whom they choose to disclose this information. People therefore create boundaries with regard to their perceptions of appropriate targets for disclosure of HIV status. Appropriate delineation of disclosure boundaries in relation to social

support is important because the ramifications can either be positive or negative (Schlebusch & Cassidy, 1995).

Family and friends subsystems seem to be the ones, which are perceived to be more supportive when it comes to people with HIV. Family members were found to be likely to buy things, while friends were more likely to run errands and offer moral support for HIV-positive persons (Kimberly & Serovich, 1996).

In a study conducted by Sowell and Misener (1997), they found that for women who have children, the family members most likely to be aware of the woman's HIV-infection are children. This means that a number of minor children are providing support to their HIV-infected mothers. If these women were to disclose to an adult family member, it was most likely the woman's mother. The women reported that their mothers' support had been invaluable in helping them cope with their disease.

The women in the above mentioned study also indicated that they also got support from their peer group of other HIV infected women. After attending a support group organised by the researchers, those women who had not previously been involved with support groups voiced the intent to join a group. They stated that the support they received from the group made them feel that they were with people who really understood them and accepted them unconditionally (Sowell & Misener, 1997).

3.2 SALUTOGENESIS

3.2.1 INTRODUCTION

The salutogenic model as first introduced by Antonovsky (1979) signifies an important paradigm shift from the commonly used pathogenic model by focusing on the origins of health or well-being, instead of examining the causes of disease. The question that is often asked is "why do some people thrive under certain stressful situations when others do not?" The salutogenic approach focuses on persons with an orientation to life that allows them to

assess a situation in such a way that they could survive in a situation that others might find psychologically, emotionally, or physically compromising.

There are several salutogenic models in use, but due to the link between Antonovsky's (1979, 1984a, 1984b, 1987) model and coping, only that model will be discussed.

3.2.2 PATHOGENESIS

The pathogenic paradigm assumes that the normal state of affairs of the human organism is one of homeostasis and order (Antonovsky, 1984a). The implication is that the normal state of the human being is a relatively constant condition, which is occasionally disturbed by various pathogens and stressors and maintained by various interacting regulatory mechanisms. Disease comes about as a result of inadequacy in these regulatory mechanisms (Strümpfer, 1990).

Strümpfer (1990) noted that psychology has followed the traditional way of thinking in a pathogenic orientation to psychological problems, thus emphasising the abnormal. The pathogenic paradigm is directed at finding out why people fall ill and specifically, why they develop particular diseases. The information obtained from such findings is then used to find ways of combating and preventing diseases. At the heart of this paradigm is also the assumption that diseases are caused by physical, biochemical, microbiological and psychosocial agents. According to Antonovsky (1979, 1984a, 1984b, 1987) the consequences of pathogenic thinking can be summarised as follows:

- People are classified as either healthy or diseased, implying that the homeostasis of people perceived to be in the healthy category is undisturbed (Antonovsky, 1984a).

- It pressures us to focus on the disease or illness and disregard the sickness. This means that the subjective interpretation of the situation of

the person who is ill is usually ignored in favour of the aetiology of the disease. Salutogenesis on the other hand studies everything that may be important about the persons who are ill, including their subjective interpretation of their state of health (Antonovsky, 1979).

- The pathogenic approach focuses on specific illness and it seeks specific immunities and cures, whereas there are factors, both etiologic and symptomatic, that are common to all forms of disease. This specific focus on certain diseases leads to disregard of these common factors (Antonovsky, 1987).

- Pathogenic thinking leads us to believe in a fallacy that all illness will be conquered one day. Antonovsky (1984b) referred to Dobus' argument that disease is an expression of maladaption to the environment, and since the environment is always changing and always producing new threats, the human being's ability to adapt to new threats should always be an important issue to be taken into consideration.

- Placing the focus on causes of diseases leaves little room for looking at coping skills. Antonovsky (1984b, p.115) emphasised this line of thinking by noting: "In other words, prime attention is given to the bugs - as noted earlier, to the specific bugs related to disease X - and not to generalised capacities for coping with bugs".

- Pathogenic thinking leads us to assume stressors are bad. In Antonovsky's opinion, the outcome of this thinking is an attempt to create a sterile environment. The probability of creating the sterile environment is not only very low, but can also be to the detriment of human beings. He suggests that stressors must be seen as having the potential to be toxic, neutral, tonic and salutary or have both positive and negative consequences.

- The pathogenic approach places emphasis on the high-risk group and as a result it tends to ignore the 'deviant cases', i.e., those who do not

become sick. Antonovsky (1984a) pointed out that when a positive correlation exists between a stressor (e.g. smoking) and a condition (e.g. lung cancer), only a part of the variance is accounted for even at a high level of probability. Because researchers do not study the deviants, they generate neither hypotheses nor methodologies to create understanding of the full extent of human health (Antonovsky, 1984a, 1984b).

Antonovsky became uncomfortable with the pathogenic paradigm when he realised that it is unable to explain data satisfactory. He pointed out that it does not account for the fact that at any time, at least one-third and possibly a majority of the population of any modern society is characterised by some pathological condition (1984a). He then asked: "How is it that not all people break down?" (Antonovsky, 1979). The above information propelled Antonovsky to formulate the salutogenic model as an attempt to answer the questions he had.

3.2.3 ANTONOVSKY'S SALUTOGENIC MODEL

Strümpfer (1990) refers to Antonovsky as the clearest proponent of the salutogenic paradigm. The word salutogenesis derives from the Latin words *salus* meaning health, and *genesis*, which means origin. This line of thinking therefore leads us to think in terms of factors promoting movement toward the healthy end of a health ease/disease continuum (Antonovsky, 1987). Antonovsky formulated his ideas after making observations of holocaust survivors and wondering how it was possible to live a normal life and keep one's sanity after such life experiences (Poppius, Tenkanen, Kalimo, & Heinsalmi, 1999).

The findings of the research conducted by Antonovsky went beyond 'health' as usually construed. They covered strength to deal with general concerns, like finances, growing old, security conditions in the country and satisfaction with family roles, as well as roles such as being a friend, neighbour, worker or volunteer (Strümpfer, 1995).

There is a generally held view that people can be classified in terms of a fundamental dichotomy of being either healthy or diseased. Those who believe in the former position allocated attention and resources to keeping people healthy and preventing them from becoming sick. The latter view forces the attention to be focused on treating those who are sick, trying to restore health, if possible (Antonovsky in Oelofse, 1996). Antonovsky views this dichotomous classification of people as an oversimplification of health problems. His perspective is that people fall somewhere on a continuum between health and illness.

The salutogenic orientation derives from the fundamental postulate that heterostasis and increasing entropy are core characteristics of all living organisms. In the course of living, people are constantly involved in minor, automatic mechanisms to maintain or restore homeostasis to keep themselves stable, both physiologically and psychologically (Antonovsky, 1979).

A stressor is commonly regarded as a demand made by the internal or external environment of a human being, which upsets the homeostasis to such an extent, that it requires a nonautomatic action to restore it. According to Antonovsky, it is not viable to define all the slight differences in the environment as stressors, since the difference between a stressor and other types of stimuli is a matter of degree. Whether a given stimulus is a stressor depends mostly on the meaning a particular person attaches to the stimulus and the available repertoire of automatic homeostasis-restoring mechanisms (Antonovsky, 1979). This explanation links with primary and secondary appraisal discussed in section 3.1.3.1.

Antonovsky (1979) believed that stressors are omnipresent in the human existence, thus explaining why many of any country's population at a given time is ill to a greater or lesser extent, despite high living standards, environmental control and medical technology. He pointed out that even people in comfortable and favourable environments are continuously exposed to fairly serious stressors.

The distinction between tension and stress is viewed to be of importance for the understanding of the way illness comes about. In Antonovsky's view, stressors are neutral in health consequences, but lead to a state of tension in the organism. If the organism copes well with the tension, the stressor may be tonic. Stress is seen as the result of poor tension management, which opens way for disease (Antonovsky, 1984b).

The characteristics of the salutogenic model (Antonovsky, 1987) are summarised as follows:

- It rejects the dichotomous classification of people as healthy or diseased in favour of their location on the multidimensional health ease/disease continuum.
- It does not solely focus on the causes of a given disease, but on the total human being including his/her sickness.
- The focus is removed from the causes of illness to factors involved in maintaining or improving one's location on the health ease/disease continuum, i.e. coping resources.
- Stressors are not necessarily viewed as pathological, but possibly salutary, depending on the character of the stressor and the resolution of tension.
- It goes further beyond the data obtained from the pathogenic enquiry by always considering the 'deviant cases' found in such an enquiry, i.e. those people who do not become sick.

There seems to be a relationship between Folkman and Lazarus' cognitive phenomenological model of coping discussed in 3.1.3 and the salutogenic paradigm as discussed above since they both look at a person in context, instead of just concentrating on cause and effect.

3.2.4 GENERALIZED RESISTANCE RESOURCES

A generalised resistance resource (GRR) is defined as "any characteristic of a person, the group, or the environment that can facilitate effective tension management" (Antonovsky, 1979, p.99). Antonovsky (1987) also refers to a

GRR as any phenomenon that is effective in combating a wide variety of stressors.

The pathogenic approach is also interested in the study of resistance resources, but only those relevant to particular diseases. The importance of resistance resources relevant to particular diseases is not denied, but Antonovsky (1979) stated that they "are all too often matters of chance or luck, as well as being helpful only in particular situations" (p.99). He gave examples of such GRRs as a certain drug, a telephone lifeline of suicide-prevention agencies, or an understanding look in the eyes of an audience to whom one is lecturing.

Antonovsky (1979) identified eight types of GRRs. They include physical, biochemical, artifactual-material, cognitive, emotional, evaluative-attitudinal, interpersonal-relational and macrosociocultural characteristics of a individual, primary group, subculture and society, that are effective in avoiding and combating a wide variety of stressors. These GRRs can be further related to coping resources like physical, social, psychological, and material assets, which are evaluated with respect to the demands of the situation as discussed under secondary appraisal in 3.1.3.1. The extent to which GRRs are available to a person is perceived to play an important role in determining the person's position and movement towards the healthy end of the health ease/disease continuum (Antonovsky, 1979).

The GRRs can also be divided into three basic categories, namely homeostatic flexibility, ties to concrete other, and ties to the total community. Homeostatic flexibility refers to the ability to accept alternatives to problems and to assess the potential outcomes of such alternatives. Profound ties to concrete others and to the community enable one to more adequately manage tension, by having greater support and stability (Antonovsky in Dohrenwend & Dohremwend, 1974).

A person undergoes life situations or experiences with specifiable characteristics or perceptions, unique to the individual. These experiences

generate, over time, a way of seeing one's world, leading us to the concept that Antonovsky called the sense of coherence.

3.2.5 THE SENSE OF COHERENCE (SOC)

3.2.5.1 Definition

While trying to find answers to questions like "whence the strength?" (Antonovsky, 1979, p. 7) and why some people are able to manage stress and stay well, Antonovsky came to the concept of the 'sense of coherence' (SOC). He defined it 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 one's 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 these stimuli, and (3) these demands are challenges worthy of investment and engagement (Antonovsky, 1987, p. 19).

Antonovsky (1979) pointed out that SOC does not refer to any specific area of life or situation or stressor. He sees it as an important component in the basic personality structure of an individual and in the surroundings of a subculture, culture or historical period. He emphasised that having a strong SOC does not mean that a person won't have problems as a result of stressors, but exposure to different stressors can effect a temporary and minor shift in a person's SOC, with changes occurring around a stable location on the health-disease continuum.

GRRs lead one to develop a strong, crystallised, integrated view of the world. Generalised resistance deficits (GRDs), such as low self-esteem, isolation, low social class or cultural instability can lead to a weak sense of coherence. The balance between the experiences provided by these GRRs and GRDs therefore determines an individual's location on the SOC continuum (Antonovsky, 1990).

H. Antonovsky and Sagy (1986) described SOC as an enduring tendency to see one's life space as more or less ordered, predictable, and manageable. Antonovsky and Sourani (1988) view the hallmark of SOC as flexibility in selecting coping behaviours that are judged to be appropriate. A strong SOC leads to the existence of the motivational and cognitive bases for transforming one's potential resources, appropriate to a given stressor, into actuality, thereby promoting health (Antonovsky & Sourani, 1988).

3.2.5.2 Components of SOC

There are three components in the SOC construct, namely comprehensibility, manageability, and meaningfulness. Antonovsky (1987) described these components as follows:

- Comprehensibility

  This component reflects typically solid capacity to judge reality. It refers to a sense that life is ordered, consistent and makes sense. It also refers to the extent to which one perceives the stimuli that confronts one, deriving from external and internal environments, as making cognitive sense, as ordered, consistent, structured, and clear, rather than as chaotic and random. A person with a high sense of comprehensibility sees his/her future as predictable, expecting things to work out as reasonable as can be expected. When things come as surprises like failures or death, such a person can make sense of them. A person with a low sense of comprehensibility on the other hand, will have contrary feelings, thinking that he/she is a loser.

- Manageability

  Manageability is defined as the extent to which one perceives that one has at his/her disposal resources that are adequate to meet the demands posed by the stimuli. Here a person is confident of his/her own resources and he/she can trust others.

A strong sense of manageability makes people to believe that the appropriate resources for successful coping with a given stressor are at their disposal. This has a strong relationship to secondary appraisal discussed in 3.1.3.1. where a person evaluates coping resources and options after appraising the situation. These resources include one's spouse, friends, colleagues, God, the physician, or any other person one thinks is on his/her side. High sense of manageability also protects an individual from feeling like a victim or as if life is treating him/her unfairly whenever he/she is faced with life's unfortunate events (Antonovsky, 1990).

- Meaningfulness

This represents the motivational element in the construct. It refers to the extent to which one feels that life makes sense emotionally, that at least some of the demands posed by living are worth investing energy in, are worthy of commitment and engagement, are challenges that are welcome rather than burdens that one would much rather do without (Antonovsky, 1987, p.18). In case of unhappy experiences, a person with a high sense of meaningfulness will most likely be willingly to take up the challenge, will probably be determined to seek meaning in it, and possibly do his/her best to overcome it with dignity (Antonovsky, 1987).

Antonovsky (1987, p. 22) further elaborated on the components by saying:

> The motivational component of meaningfulness seems most crucial. Without it, being high on comprehensibility or manageability is likely to be temporary. For the committed and caring person, the way is open to gaining understanding and resources. Comprehensibility seems next in importance, for high manageability is contingent on understanding. If one does not believe that resources are at one's disposal, meaningfulness will be lessened and coping efforts weakened. Successful coping, then, depends on the SOC as a whole.

The above indicates that although the three components can be distinguished, successful coping depends on SOC as a whole and not just on a specific component.

The SOC deals with outlook on life. According to Antonovsky persons high on SOC are more likely to stay healthy more often than those low on SOC. Factors affecting SOC are identified as stressors, adaptation and coping. But as Antonovsky's (1987) outlook is salutogenic, the stressors are not always the negative stressors as indicated earlier in this study.

3.2.5.3 SOC and Boundaries

Having a strong SOC does not mean that the person experiences everything in life as highly comprehensible, manageable and meaningful (Strümpfer, 1990). According to Antonovsky (1987) people set boundaries, and what happens outside those boundaries does not matter. This boundary notion suggests that a person need not necessarily feel that all of life is highly comprehensible, manageable, and meaningful in order to have a strong SOC. Some people's boundaries can be wide, some narrow, implying that a person can exclude various spheres of life. Antonovsky (1987) believed that for a person's life to be meaningful, his/her boundaries should never exclude the following spheres:

- a person's own feelings
- his/her interpersonal relations
- the major activities he/she engages in, such as work or being a housewife
- existential issues like death, inevitable failures, isolation, conflict and shortcomings.

Flexibility about areas of life, which a person includes within the boundaries, may be an effective way through which a person with a strong SOC maintains a coherent view of the world. Boundary control (flexibility) can be done by adding or including new areas within the boundaries, or by temporarily or permanently removing from an area where demands are becoming less

important and less comprehensible and manageable (Antonovsky in Oelofse, 1996).

Antonovsky (1979, 1984a, 1987) emphasised that acceptance of the salutogenic paradigm does not imply total rejection of the pathogenic paradigm. Antonovsky and Bernstein (as cited in Oelofse 1996, p.13) reflected on a their friend's remark who said: "when I have cancer, I want to be treated for cancer, not for the sense of coherence".

3.3 CONCLUSION

This chapter looked at different approaches to coping with a specific emphasis on the cognitive phenomenological model of coping. The salutogenic orientation, which focuses on finding out how people manage to stay healthy, was also discussed. The next chapter consists of a detailed description of the manner in which the research process was conducted.

ERRATA

Change the word "loose" to "lose" on the following pages

p. 10, line 22

p. 69, line 9

p. 71, line 28

p. 72, line 11

p. 74, line 12

p. 80, line 14 & 15

Change the word "loosing" to "losing" on

p. 17, line 11

p. 72, line 5, 6, 8

p. 80, line 10

p. 82, line 11

p. 11, line 19: "women are" should be "women were"

p. 12, line 21: "legions" should read "lesions"

p. 17, line 25: "reported against" should be "reported by"

p. 17, line 26: "occur" should be "occurs"

p. 25, line 27: "undimensional" should be "unidimensional"

p. 35, line 9: the word "her" should be inserted before "children"

p. 41, line 13: "a individual" should read "an individual"

p. 46, line 6: "a" should be inserted before "friend's"

p. 53, line 10: "hem" should be spelt "them"

p. 63, line 10: the word "a" should be inserted before "few"

p. 71, line 21: "concern and" should read "concern with, and"

p. 85, line 21: "live the way" should be living the way"

p.92, line 6/7: "Hate feelings" should be "Feelings of hate"

p. 96, line 25: "other people" should be "some people"

p. 101, line 7: "a" should be inserted before "daily"

p. 103, line 8: the word "the" should be inserted before "better"

p. 103, line 29: "by another should read "to another"