From Where does Our Health Come?:
The Sociology of Antonovsky's Salutogenesis

Mitsuho Ikeda and Sookja Suh*
(Center for the Study of Communication-Design: CSCD, Osaka University; *Visiting Scholar of CSCD, Niigata Collage of Nursing)

Abstract
In this paper, the authors examine critically the salutogenic theory/hypothesis addressed by Aaron Antonovsky (1923-1994). To remark our conclusion, the potential of salutogenic theory, which we value, should be highlighted in terms that it pointed out that health of human-beings is a dynamic and multi-dimensional status, and it has relative and more pragmatic aspects. We rather deem that the success in the measurement of Sense Of Coherence (SOC) using psychometric scales is less important, despite the fact that Antonovsky himself had high opinion on it as well as his peer scientists and the followers do. The authors discuss how we can develop the legacy of the research done by Antonovsky, focusing on the potential of qualitative research method.

Key words
Salutogenic theory, Aaron Antonovsky, *healthism*, positive health, medical sociology and anthropology

1. The Naturalist Fallacy of Health Theory

In *Principia Ethica* (1903), George Edward Moore questioned the ethical judgment that nature or the things under the rule of nature is "goodness." One might firstly remind "health" as something good and this statement seems acceptable as health apparently derives from nature. However, death as well is a natural phenomenon under the rule of nature and so is illness. Therefore, it falls in a logical collapse to say that health is good because it comes from nature. For us, being good and being natural are not relevant with each other. Accordingly, Moore suggests that we should not to associate health with goodness because both health and illness embrace the concept of good and evil — *a priori* value judgment — in their property. In order to replace this invalid relevance of health and good, we can apply "normal and abnormal" to "health and illness" so that the scientific judgment can be released from the value judgment of good and evil. It is a suggestion of taking a premise that normal submits to nature and not does abnormal.

It is worth remarking that Moore pointed out that being good not synonym of nature. To explain further, let us say, it is no more a logical persuasion to justify the judgment that organ transplantation or euthanasia can be "evil" because it doesn't follow the rule of nature. On the other hand, saying, "I myself don't mean to object to the idea that health is good," Moore warns us: the

proposition that health is good should be considered as an unsolved problem and must not be treated as self-evident. Because we will end up with "naturalist fallacy" noted above if we determine it is self-evident (*Principia Ethica* §10). It seems that we simply call health *post hoc* fact to refer the particular state that can be identified as "good." Then, looking back for this century since Moore's warning, how far has our thought reached? Health scientists — those engaged in quantitative studies to establish scientific evidence in the area of medicine, health, nursing and so on — are hoping to contribute to the enhancement of human health, but they mostly end up with self-satisfaction believing that their research are walking in the light of the verity of nature. Despite their glorious achievement in biomedical sciences, yet, we find in our own daily observations that common people never stop seeking health and pose consistent demands on health specialists. The demands by common people are eclectic and they are undoubtedly in a state of "starvation" deprived from well-being and/or health. This means that the science outcome has never caught up the "health demands" by common people. This situation can basically be attribute to the bio-medicalization[1] of health and industrial commercialization. However, there are some other reasons, which are accordingly making this dismal situation much worse. The majority of health scientists should be indulged in their own rats races and paper chases, and have been missing thinking deeply over some important questions; in what way health can be defined, and what is the phase relation between health and something judged as good.

In this standpoint, the authors will examine critically the salutogenic theory/hypothesis addressed by Aaron Antonovsky (1979, 1988). To remark our conclusion beforehand, the potential of salutogenic theory, which we value, should be highlighted in terms that it pointed out that health of human-beings is a dynamic and multi-dimensional status, and it has relative and more pragmatic aspects. We rather deem that the success in the measurement of Sense Of Coherence (SOC) using psychometric scales is less important, despite the fact that Antonovsky himself had high opinion on it as well as his peer scientists and the followers do. The establishment of the method to measure SOC contributed to disseminating the easy tools of propagate. However, the development of quantitative research in SOC did not contribute to the further elaboration of salutogenic theory — a counter-concept of pathogenic theory/hypothesis that modern medicine embody — in regard with qualitative research method.

Hereafter, the authors will discuss how we can develop the legacy of the research done by Antonovsky, focusing on the potential of qualitative research method.

2. The Origin of Antonovsky's theory and its preliminary speculation

Until the late 1970s, Antonovsky had already started his life-history studies of Jewish female born in Central Europe between 1914 to 1923. And his book written with Nancy Datan and Benjamin Maoz published in 1981, was grounded on the research of which objects were middle-aged women with diverse cultural background who were born between 1915 to 1924 and lived in Israel (Datan et al. 1981: 2). They were the women who had been aged sixteen to twenty five in 1939, that is to say, when the Nazi began to send Jews and others to concentration camps. As it was expected, the ratings of a group of concentration camp survivors in the emotional health was obviously ($p < .001$) low compared to those of a [statistical] control group. And while 29% in the group

of concentration camp survivors, in the control group, the ratio of those keeping better emotional health was 51%. It was presumed that having experience of the concentration camp gave negative effects to their emotional health. Nonetheless, why were a little under one third of the concentration camp survivors able to be in reasonable emotional health?

At first, Antonovsky could not find any clear explanation for what he had observed. These women had had at minimum three environmental stressors until then. They are, namely (1) the concentration camps, (2) living in exile after World War II, and (3) three Middle-East Wars. Even after experiencing harsh stress situation, one-third to a half of the population kept reasonable health. Antonovsky discovered that stressors caused some responses in living organism that enhance positive function.

He describes,

> "Evidently a shock stressor can have salutary consequences for an organism, provided it is escapable. But when one thinks only of the pathogenic consequences, one misses the vista that such a finding (= *view or claim that capability to control stressors is mislead as the state that immune suppression is not working*) opens up" (Antonovsky 1988: 1, *added by the authors*).

In addition, it is assumed that he was aware of the effect of stress coping derived from the environment as well as the responses at the organism level. Specifically, he describes, "Being high on stressors, given high social supports, is salutary" (Antonovsky 1988: 8). Having come by this original idea, Antonovsky addressed his new theory "Salutogenic model" in *Health, Stress, and Coping* (1979). What is central in the salutogenic model is that it indicates the limit of pathological orientation, *pathogenic*, which has been the fundamental paradigm in biomedicine, emphasizing the other-way-around thought based on "*salutogenic* orientation." Below shows the theoretical framework of "salutogenic orientation."

The model comprises the idea that health *i.e.* health-ease and illness, dis-ease should not be

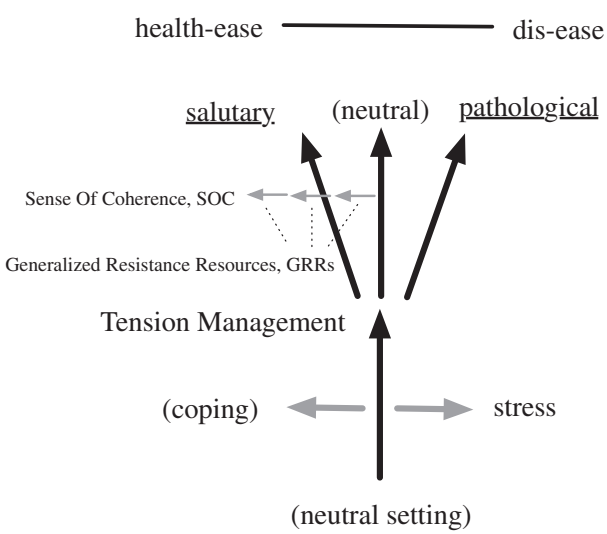

Fig.1. *Aaron Antonovsky's* Health-ease/Dis-ease Continuum and the function of GRRs
(Designed by M.Ikeda, 2015)

considered dichotomic and mutually exclusive but rather seen as two ends that form a continuum (=health-ease/dis-ease continuum) upon which we can find the health status of individual (*See* the Chart).

Amongst the factors involving salutogenic process, utmost importance was given to the concept of Sense of Coherence (SOC). The concept of SOC prepares for a hypothesis not only to interpret why some people are able to survive, but also, to stay in healthy condition under a harsh stress situation. There is not a deduction that maintaining strong SOC brings health to individuals. The interview records in the Antonovsky's study imply that the individuals with weaker SOC, when they are informed how SOC is observed in actual life situation, are likely either to accept the SOC without questioning regardless of their original thought, or, on the contrary, to deny the idea of SOC. In the meantime, the conditions that keep stronger SOC include optimism and flexible response for successful adaptation. SOC is a state of inner consistency held by individual, and expressed as a conviction born of the subjective experience of individual in concordance with the logical construct of SOC. Antonovsky himself defined SOC as follows; "*The sense of coherence is 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, 1998: 19). Now, with reference of the concept of SOC in the preface of Antonovsky's work in 1988, the authors are going to re-conceptualize the characteristics of SOC, indicating the four components below as we identify;

(a) Consistent perception about the world: "persisting conviction", "conviction that the interior and the exterior environments are predictable,"
(b) Rough and easy perception: the sense that "events are by and large predictable,"
(c) Optimism: conviction that "it is very likely that things work well,"
(d) Perception with which life world is filled: "dispositional orientation towards the world" (Antonovsky 1988: xvii, 182).

SOC is constructed by the component called GRRs, *i.e.* Generalized Resistance Resources. GRRs are explained as the components or, literally, the resources from which SOC emerges. For instance, Antonovsky describes that "GRRs are defined as *potential* resources [to emerge SOC; added by the author]" (Antonovsky 1988:xvi). Additionally, the function of GRRs, interacting with the individual actor, is to help find the meaning of the misfortune as stressor inflicted on him/her and to make easier to cope with it. Specifically, "(i) what is common to all GRRs, I proposed, was that they facilitated making sense out of the countless stressors with which we are constantly bombarded. (ii) In providing one repeatedly with such experiences, they generate, over time, a strong sense of coherence. (Antonovsky 1988:xiii, numbers added by the authors)." As seen above, Antonovsky's explanation implies that the GRRs involve the principle of daily practice by the individual. For instance, in his book published in 1988, Chapter five is allotted for the discussion on "the child-rearing patterns and subcultural and cultural patterns of social organization that build up the GRRs out of which a strong SOC emerges" (Antonovsky 1988:xvi).

3. Sensing SOC: Revival of qualitative interview method

As we indicated at the end of the section 1 in this article, we do not value very much the psychometric measurement of SOC contrary to the appraisal it has gained in academia. That is because, contribution of the "discovery" of the SOC, we believe, lies not in the development of the measurement method, but in formulation of the versatile term to interpret the experienced facts of Jewish women who are in reasonable health even after the collective passion in history. In the early age of his academic life he enjoyed in his birthplace North America, Antonovsky dedicated himself to research on cultural anthropology, notably, to the study of "culture and personality," of which theoretical premise influenced the formulation of the SOC. In this sense, the general principle of illustrating the SOC could by no means be unitary but rather diverse, being modified by the culture or being given various meanings through personal experience.

Antonovsky cites the series of studies done by Hans Selye (1907-1982). He also studied with Eric John Cassel (1921-1976), an epidemiologist from Johannesburg, and he used to apply to both theories that provide scientific evidence for his SOC effectiveness. Meanwhile, Antonovsky advised his students who conducted qualitative interview to consult about the "concept of the story telling;" which we call "narrative" and was addressed by Eric John Cassel, then Antonovsky taught sociology of medicine at the Ben-Gurion University medical school after 1972. The main idea is that there is a personal "story telling" of the patient that is closely related to the course of the "illness." And it implies the importance of getting a picture of the person's "story telling" when the treatment providers face the patients' illnesses. In this regard, the Cassel's concept of the story telling might remind us of the lately developed "narrative analysis" which involves in better understanding of the patients and in better medical practice, which these two actually do not have close relation with each other. Antonovsky relates an experience Cassel himself had, concerning the importance of the story telling in his book.

> "In it he (=*Cassel*) tells of the elderly patient hospitalized for a serious, advanced problem of the knee. Symptom identification, diagnostic hypothesis, confirmation, and institution of appropriate therapy followed in short order, leading to discharge and ensuring re-hospitalization in short order. For what was learned only by accident by a medical student was that this elderly gentleman had been widowed a year before, had moved to this strange city where he had no friends or relatives, had only a small income, and lived in a fourth-floor walk-up. The knee was very real and very serious. This was what had led to hospitalization this time; the next time, it could have been malnutrition, pneumonia, or depression and suicide attempt" (Antonovsky, 1998: 5, *added by the authors*).

As this brief description implies, a "story telling" is not what was told superficially, but a shared experience between the patient and the listener in which the latter could reach the deeply hidden aspect of life of the former. To reach a "real story," something more than transcribing the interview sessions is required. It requires deep compassion or rapport for the "lived experience" in phenomenological sense, of researcher him/herself.

Then, here is another episode to remark.

《Episode》

"In November 1982 I was teaching interviewing to beginning medical students in Israel. The setting was a well-baby clinic, the reluctant interviewee a twenty-six-year-old mother who had brought her three-week-old infant, while her fourteen-month-old little girl trailed behind Her reluctance, the nurse told us, was understandable: her four older children waited at home. After a few words about the uneventful delivery, she remained quiet in response to the student's next question, which referred to the presence of her husband at the delivery. Fortunately, she had learned how to wait patiently and use nonverbal expressions of concern. The woman then told him, in almost in-audible words, that her husband had been killed in the fighting in Lebanon some four months earlier: The rapport had been created, and she began to speak, going on for nearly an hour. At first, the picture that emerged was the one we had expected. The terrible blow could not be recalled But the Rehabilitation Division of the Ministry of Defense had already arranged her move to a more spacious apartment, an adequate pension, financial assurance of her children's education, and the like. The diagnosis had been made, the therapy designed. / But the student, who had learned Cassel's concept of the story, had been taught to get a picture of the person's life, and patiently elicited what no one else had been successful in learning. As a child, her father had raped Mrs. R. Pregnant at sixteen, she had had no alternative but to marry the man whose death had made her a war heroine. She was often beaten, related to as a baby-making machine, and no more than occasionally provided for financially. The death had been the most fortunate thing that had ever happened to her. For the first time in her life, she now had the possibility — no more than that — of a decent human existence. Clearly, her strength was in adequate to transform this into a reality. Solution of financial problems, the assigned therapy, was necessary but far from sufficient. It was a magic bullet, not an adequate basis for active adaptation" (Antonovsky, 1998: 9-10).

To close this discussion about the SOC, we would like to choose three examples of "narratives" from the Antonovsky's work in 1988 in which the respondent interviewees mentioned religious belief. In the 1988 book, Antonovsky did not explicitly deal with the influence of Judaism upon his concept of SOC. Still, the theme of faith was fairly common in the speech of those people with stronger SOC and they were more likely to be positive about it, while in the interviews with those with weak SOC religion was hardly brought up for the topic, or, if spoken, they doubted of it.

According to the evaluation done by Antonovsky himself, the following Narrative One and Two were spoken by the respondents with strong SOC. And the last one, Narrative Three, was spoken by the respondent with weak SOC.

《Narrative on faith: One》

"How we overcame all the difficulties in our lives? You need patience. You have to believe in the Promise, a word I learned in Bulgaria. ... It doesn't have to be God. It can be another force, but you have to have faith. Otherwise you can't suffer so much and go on. ... How can your health be when you're so old? But I have no complaints. ... I don't see so well, I can't read, that's what bothers me. I work in the center for the blind about three hours a day, together with my wife... I've always worked, and always looked for work." *Male, 90, Married with two children,*

retired, economic deprivation (Antonovsky, 1998: 68). — Individual with high SOC.

《Narrative on faith: Two》

"I don't get mad, always laugh and sing. [After describing all he learned and dreamt about Zionism and Israel] When I finally came, things weren't strange, I understood what was going on. ... /... I'm religious, but not a rabbi.... I love Judaism, tradition. It makes me feel optimistic, real optimism. I always say that things will be good.... I never despair.... I have nothing to complain about. It's all a matter of will. ... I'm only sorry I'm not yet married ... What I can do, I do; what I can't, well ... You have to take life as it comes." *Male, 42, Divorced, switch-board operator, blind since age three* (Antonovsky, 1998: 70). —Individual with high SOC.

《Narrative on faith: Three》

"I believe in fate. True, I don't know who runs it, because I don't believe in God anymore." *Female, 50, Widow with two children, housewife, her husband had died three years earlier* (Antonovsky, 1998: 72). —Individual with high SOC.

4. Circular argument in Antonovsky's theory

Antonovsky argued that achieving or recovering health entails in individual as an subject (1) the social-physical mechanism which generates health and (2) Sense of Coherence, *SOC*. The former is Salutogenesis — the theory of generating health which emphasize the function of the sanitary factors — the factors which give effect on health both to the individuals with good health status and to the society they belong to. And the latter indicates that we can enhance own health status when the linkage between physical and social components (in other word, the sense of coherence) is organized. In addition, Antonovsky and his colleague researchers gained positive recognition for the "establishment" in the measurement of the SOC applying the technique of Likert scale.

However, Antonovsky's argument on the relationship between GRRs and the well-being of individual/society postulates an indirect causal effect and makes a circular logic. In this regard, he argues; the SOC and GRRs correlate with each other and GRRs produce well-being though well-being itself does not directly affect SOC.

《Explanation on how GRRs and SOC are relevant to well-being: 01 》

Clearly, if one has a high intelligence, lots of money, or a clear ego identity or lives in a stable, integrated culture to mention some GRRs-there will be consequences not only for the emergence of a strong SOC, and therefore health, but for other areas of well-being as well. I would, therefore, by and large expect positive correlations between the SOC and many facets of well-being to the extent that the GRRs which create the life experiences that give rise to a strong SOC also directly promote well-being. If one is happy with one's financial situation, this is not because one has a strong SOC but because one has a satisfactory income (Antonovsky, 1998: 181)

《Explanation on how GRRs and SOC are relevant to well-being: 02》

In sum, I think it reasonable to expect positive, though not directly causal, correlations between the

SOC and well-being, on two grounds. First, if the SOC is indeed generative of good health, and health has a positive influence on global estimates of one's well-being, then the two will be related, though indirectly; Second, many of the GRRs that promote a strong SOC are also directly related to well-being. But there is, I think, a more direct causal relationship, one that requires refinement and specification of the notion of well-being into two different levels of abstraction. One can distinguish between, on the one hand, the more global referents such as happiness, life satisfaction, morale, and positive (as well as negative) affect and, on the other hand, how one feels about one's functioning. The former is strongly contingent on the inherent potential in the objective situation; the latter will be much more directly related to the SOC (Antonovsky, 1998: 181).

5. The significance of Antonovsky's theory

The theoretical implication of the SOC determines (a) the intervention for the individual (and the group he/she belongs to) and (b) the reconstruction of the life context or the environment as the way of enhancing SOC. In other words, SOC involves in two interrelated aspects, namely, (1) the potential in the individual's ability, how one can practice adaptively to the context (= "locality of practice") and (2) the potential of the locality with which an individual can utilize. These two are similar to the concept of the "faculties in locality of practice" that the author addresses (Ikeda, Online).

Beyond the transition of time and culture that creates diversity in people and their lives, how can SOC be made possible? The answer for this question is left to be discussed. What the philosophy of Antonovsky's theory tells us is that we are to live, over the course of life, "adapting" ourselves to various social restrictions or given environmental conditions and in that purpose we need to utilize our own physical and psychological potential so as to maintain stronger SOC. In order to choose the environment which increases the SOC (*i.e.* provides the positive GRRs) and to avoid the one which decreases the SOC (*i.e.* provides the negative GRRs), no one but oneself and the people surrounding him/her have to act self-directed. That is because maintaining strong SOC is equal to "live better." In that sense, SOC constructs a principle of practical ethics to promote the function of salutogenesis. A Japanese medical sociologist, Yoshihiko Yamazaki once mentioned, "new paradigm is necessary in the human-to-human service area all over the world to pay more attention to positive nature of human-beings and to focus on developing it" (Yamazaki, 2008: 53). It is exactly this principle of practical ethics that establishes such a paradigm.

Kantian philosopher says that it is impossible to find rational basis to explain the superiority of practical reason, but every demand raised in moral life urges us to assure its truthfulness. Then, the individual's reason can do nothing but to submit the proposition. Unless the word "should do (*sollen*)" makes sense, we can do what we should do. When an individual determines one's own will be guided by such rules, it can be said that the one has freedom (*die Freiheit*) as Kantian philosopher says. Therefore, freedom is the premise for the intrinsic attribute of will in all the rational being (cf. Gilson 1999[1937: 234-235]).

6. Conclusion: What can we learn from Salutogenic theory?

Yamazaki (2008: 49, 53) also pointed out that the SOC is a sociological and anthropological concept. What can we learn from the SOC if it is so? We can find it in the practical application of SOC theory.

The concept of the SOC is an explanatory theory derived from Antonovsky's "wonder" (interest) that 30 percent of his study subjects were able to keep physical and emotional health despite experiencing severe stress condition in their past. First, the causal relation between the strong SOC and health status was presumed, and then, the method of measurement for quantitative description was developed in use of psychometric scale. Later, transitional change of the SOC became a hot topic, and people sought the strategy to maintain the strong SOC at the end. As the authors understood, the victory of the SOC theory is all about the discovery of "salutogenic creativity intrinsic to human-being," and the setback for the *instrumentalization* of the SOC by measurement scales. The latter, setback in our words, which brought "academic creativity" to those studying SOC, made the tool of the propagation available for them to test and write.

The SOC theory has added a new view to human being that an adversity can be an origin of salutogenic creativity however harsh it is. It seems like a paradox. But it will surely promise a harvest of thought on health in the twenty-first century. In the past, Frederick Dun, Rene Dubos and others had criticized the "definition of health"[2] in *the Constitution of the World Heath Organization*, WHO (1946) as "being static, unitary, absolute and utopian." Today the new idea on health will be created in response to this criticism after over seventy years. The potential of human being, and the health, is dynamic, pluralistic, relative, sometime assertive and very realistic! — Is the idealistic concept of health down to earth?

In 1978, The *Declaration of Alma Ata* by WHO expressed that the achievement of health and the health rights is the issue to be solved by people themselves. In 1986, the *Ottawa Charter for Health Promotion* called for urgent action by all the government to protect and promote the health as basic human rights. These were compelling but with positive anticipation. Nonetheless, the public "health demands" by common people are more or less the same as that in 1978 and before, which makes us "wondered." We can say ironically "these people are starving for health." This "wonder" is a contrast to the "wonder" felt by Antonovsky when he found the group of people who were healthy after severe condition like as atrocities or extermination camps. Is the ardent desire, "*hunger for health*," satisfied by enhancing the SOC? We have no idea about it but we believe that it is worth trying. It is now to start explore in order to make a *qualitative turn* in health research[3]. The way will be open where the health scientists and the individuals with strong SOC speak to each other.

Notes

1) Medicalization is the process in which human condition and trouble come to be defined by professionals as medical problems. Under this social process the people think that their badness should be treated and prevented by medical professionals. Bio-Medicalization of health is the process in which health concept and practice of human body issues come to defined by biomedical frame of

reference, e.g. Receiving routine health checkup, consumption of health foods authorized by medical doctors, and so on.

2) The Constitution says, "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity," in its preface (adopted by the International Health Conference held in New York from 19 June to 22 July 1946, signed on 22 July 1946 by the representatives of 61 States, and entered into force on 7 April 1948) .

3) As mentioning to "*qualitative turn*," we never forget the importance of interpretive anthropology by Clifford Geertz (1978) and his hermeneutic approach in social sciences (King et al., 1994: 38-40).

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Japanese Abstract

私たちの健康はどこからやってくる？：アントノフスキーの健康生成論について

池田光穂（大阪大学コミュニケーションデザイン・センター：CSCD）
徐淑子（新潟県立看護大学、大阪大学CSCD）

要約
この論文では、アーロン・アントノフスキー（Aaron Antonovsky, 生没年1923–1994）の健康生成論について著者たちは批判的に論じる。具体的には、健康生成論の価値は、人間の健康の動態的で多面的な価値についての質的側面を明らかにしたことにあると考え、一般的に指摘されているように首尾一貫感覚（SOC）の精神測定的な数量尺度化にその価値があるのではないと主張する。それゆえ、著者たちはアントノフスキーの質的な方法論に焦点をあてて、彼の研究上の遺産を今後どのように継承すべきなのかについて論じる。

キーワード
健康生成論、アーロン・アントノフスキー、ヘルシズム（健康至上主義）、ポジティブ・ヘルス、医療社会学、医療人類学