Wellbeing for homeless people: a Salutogenic approach

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SUMMARY

Homelessness affects considerable numbers in the UK and is caused by poverty and social exclusion. Much of the literature on housing and health is disease centric, where the experience of homelessness is described as traumatic, disempowering and socially isolating. Based on the Salutogenic approach, which calls for a positive orientation on health, the aim of this study was to explore the subjective lived experiences of wellbeing in the situated context of homeless people’s lives. Nine in-depth qualitative interviews with temporarily housed adults (>25 years) in a socio-economically deprived region of North-west England were held. Accounts of renewed self-confidence, perceived resourcefulness and continual personal participation are said to be supporting wellbeing. A strong belief, or sense of coherence, in internal and external general resistance resources was a critical enabling factor for those living in temporary accommodation. Wellbeing was consistently linked with both social and formal activities; keeping occupied and having a strong sense of purpose were essential to wellbeing. In utilizing a Salutogenic approach we demonstrate how the ‘context and meaning’ of health actions can improve the understanding about the kinds of factors influencing wellbeing.

Key words: homelessness; Salutogenesis; health promotion discourse; qualitative research

INTRODUCTION

The value of adopting a broader more positive orientation towards health, as opposed to illness and disease, has long been recognized within the field of health promotion. Despite some evidence of a paradigmatic shift emerging, this remains highly theoretical, largely involving narrow definitions of health, with limited relevance to practice. Practical examples of a more positive orientation in addressing substantive health and social care issues, such as the link between health, housing and wellbeing are needed.

Indeed, having access to appropriate housing is not only problematic in times of economic crisis but a basic social requirement and as such, a fundamental prerequisite for health within original charters for universal health improvement (WHO, 1986). Homelessness both causes and is caused by poverty and social exclusion, including financial problems, lack of work and deterioration in mental and physical health and social injustice. In the UK homelessness, however defined, affects considerable numbers of people. In 2008 some 141 000 people per annum were reportedly displaced or homeless across the UK (Shelter, 2008). A disproportionate number (25%) of people...
accepted as homeless by English local government are from ethnic minorities (The Poverty Site, 2012). Recent data suggest a reduction in homelessness in recent years; however, changes in the way homelessness is defined may conceal the true extent of homelessness in the UK (The Poverty Site, 2012). The most common reason for becoming homeless is loss of accommodation provided by relatives or friends, with a further 20% due to relationship breakdown.

Much of the literature on housing and health is disease centric, where the experience of homelessness is described as traumatic, disempowering, socially isolating (Smith et al., 2008) and impoverishing (Shelter, 2004; Smith et al., 2008). One survey, of 1500 homeless people, aged 45–64 years, reported 25% increased risk of premature death compared with non-homeless people (Gould, 2005). Levels of physical and emotional ill-health and disease is also considerably higher amongst homeless (Credland and Lewis, 2004), as is mental distress (Shelter, 2008) and social deprivation and disadvantage (DoH, 1999). Others have shown that socio-cultural displacement and isolation hugely influence an individual’s perception of health and wellbeing through reduced access to health or social care, delayed presentation of preventable conditions at the level of primary care (Power et al., 1999) and increasing attendance at accident and emergency departments (Boreham, 2008). Besides individual suffering, the social and economic burden of homelessness, in terms of increased expenditure on income support, out-of-school provision, incapacity benefits and health service costs, is also substantial at an estimated £500 million per year (Mitchell et al., 2004). Equally important is the impact of the negative stereotypes on homeless people; judged to be living ‘chaotic’ lives. Within the media homelessness has become synonymous with undesirable, immoral or unhealthy lifestyle, poor health choices and ‘risky’ behaviours (Hinton et al., 2001; Smith et al., 2008) resulting in stigmatization of homeless people (Hinton et al., 2001). While many homeless people express positive appreciation of services and medical care, many feel they are judged and treated as a homeless person who is ‘ill’, rather than an ill person who happens to be homeless (Nathaniel et al., 2008). Not surprisingly many homeless people feel an immense sense of powerlessness (Shelter, 2008). With the current economic crisis affecting much of Europe, minimizing the negative impact of homelessness is increasingly important in promoting health.

Health promotion advocates the importance of enabling people to gain an increased sense of control over circumstances affecting their health, (WHO, 1986) and ‘providing all people with the opportunity to lead a socially and economically productive life’ (WHO, 1984). Leading experts in health promotion have made repeated calls for a shift in emphasis away from the disease-centric model and modification of individual risk factors (Kickbusch, 2003); however, examples from the field of what the alternative approach looks like, have been limited. Moreover, research involving people’s subjective experience of health, and the resources involved in maintaining or promoting wellbeing needs to take place within, rather than divorced from, the different social contexts in which people live. More recently, strategies promoting health and improving quality of life have turned to a positive orientation of health, and as with this study, commonly focus on health as synonymous with ‘wellbeing’. Such positive orientation, while welcome, is by no means recent to the field of health promotion. Antonovsky’s work on Salutogenesis (Antonovsky, 1979, 1987) developed and expanded upon by Lindstrom in partnership with Eriksson (see, e.g. Lindstrom and Eriksson, 2010) first articulated the positive orientation to health, advocated by the WHO and field of Health Promotion. More recently, the focus has turned to ‘assets-based approaches’ (e.g. Morgan and Ziglio, 2007) as a useful framework for understanding health in its broadest sense, including the maintenance of personal health and wellbeing under adverse circumstances.

The present study was prompted by the principle investigators (PI) combined experience in health promotion including voluntary work in homeless settings and an interest in the Salutogenic perspective. This paper describes a qualitative inquiry into how a small, socially situated group of homeless people describe how they manage or maintain their own wellbeing in adverse circumstances. In keeping with constructivist methodology we avoided imposing a particular definition of wellbeing; rather we purposefully explored this from the perspective of homeless people. Central to this work was the use of Antonovsky’s framework and Lindstrom and Eriksson’s theoretical work around Salutogenesis to try to understand the strategies
used by participants to successfully manage wellbeing.

THE SALUTOGENIC PERSPECTIVE

The Salutogenic perspective is gaining renewed popularity within the fields of health promotion and public health. Current leaders in the field argue the Salutogenic perspective is particularly useful to health promotion research because it relates to (i) the ways in which individuals understand the situations they find themselves, (ii) suggests reasons to improve health and (iii) identifies the necessary power and resources to cope with the adversities inherent to life (Lindstrom and Eriksson, 2005).

Salutogenesis, and Salutogenic principles, are founded on positive concepts of health. Billings et al. (2010) describe Salutogenesis as a ‘stress-resource orientated concept’ about individual and collective coping, originating from the work of Aaron Antonovsky who explored factors that keep people healthy, especially under difficult circumstances. Others refer to Salutogenesis as moving people in the direction of positive health (Eriksson and Lindstrom, 2008), on what Antonovsky referred to as a ‘health-ease/disease continuum’ (Antonovsky, 1996). There are essentially two theoretical dimensions to this work. Antonovsky originally argued for greater attention to ‘generalized resistance resources’ (GRRs), or the ‘properties of a person’; a collective or a situation that facilitate successful coping against the inherent stressors of human existence. Typically, although by no means comprehensively, GRRs include material and emotional factors such as money, knowledge, experience, self-esteem, healthy behaviour, commitment, social support, cultural capital, intelligence, cultural traditions and one’s view of life (Antonovsky 1996; Harrop et al., 2006).

Antonovsky also argued for consideration of people’s ‘sense of coherence’ (SOC), together with the importance of empowering people to use and re-use GRRs effectively, to take greater control over their life, thus contributing to a positive sense of health and wellbeing (Eriksson, 2007). Eriksson and Lindstrom (2006) conclude that persons with a strong SOC are more likely to experience health positively. Three separate concepts contribute to SOC (i) comprehensibility—a belief that things happen in a predictable fashion and a sense that you can understand events in your life and reasonably predict what will happen in the future; (ii) manageability—a belief that the resources are available and that things are manageable and within your control and (iii) meaningfulness—a belief that there is good reason or purpose to care about what happens (meaningfulness) (Antonovsky, 1987; Eriksson and Lindstrom, 2005; Harrop et al., 2006).

Much of the work on Salutogenesis has been derived from cross-sectional studies of SOC (Harrop et al., 2006), drawing upon Antonovsky’s original SOC-29 Orientation to Life Questionnaire (consisting of 29 items measuring comprehensibility, manageability and meaningfulness to measure SOC), which is a widely accepted valid and reliable quantitative instrument (Anson et al., 1993; Antonovsky, 1993; Holmberg et al., 2004; Lindstrom and Eriksson, 2005). Others, however, have argued that qualitative methods are useful and relevant for enhancing understanding of how people develop SOC (Eriksson, 2007). Some suggest illuminating the processes relevant to the lived experience of participants (Ungar, 2003), and exploring minority voices and localized definitions of positive outcomes (Delfabbro and Harvey, 2004) and concepts of health would be more fruitful in understanding and enhancing health and the subjective concept of wellbeing. We purposefully set out to explore lay beliefs of wellbeing, in its broadest sense, using a positive orientation, in the situated context of homeless people’s lives; thus aiming to provide unique insight into those resources inherent to participant’s lives and believed to be enhancing their wellbeing. In doing so, we also contribute to the existing knowledge from qualitative studies in exploring socially situated experiences of SOC and the mechanisms involved and to encourage further studies of the Salutogenic framework in health promotion practice.

METHODS

Context

Whilst enrolled on a Masters Public Health (MPH) the PI worked as an interested volunteer project worker at the research site (a non-governmental charitable homeless hostel in Northwest England, in a socially deprived area of inner city).
Approach and study design
This paper describes a qualitative study using qualitative interviews to explore the subjective lived experiences of homeless people and relates primarily to the ‘properties of a person’; a collective or a situation that facilitates successful coping against the inherent stressors of human existence such that participants manage and maintain their own wellbeing. For pragmatic reasons, such as increased likelihood of attrition due to mobile or nomadic tendency of the population group, single interviews held over a time-limited period were chosen.

Recruitment
A convenience purposive sample of nine people, living in temporary accommodation, defined as homeless (i.e. on social housing register, waiting re-housing, without legal rights to occupancy or in certified unfit accommodation), was recruited to the study. Approximately 150 residents lived at the hostel on a temporary basis, serving single homeless young people (16–25 years) and adults (>25 years). Prior permission to conduct the research was obtained from management with senior staff acting as ‘gatekeeper’ to the organization and access to respondents. Participants were recruited informally by poster and word of mouth. Participants were required to opt into the study and residents showing interest received verbal and written information about study procedures. Assurances of confidentiality and anonymity were given before seeking written consent to participate. No financial incentives were offered. Ethical approval was obtained via University ethics committee.

Data collection
Our primary objective was to explore homeless people’s accounts of how they manage their individual and therefore subjective interpretation of wellbeing. Initial informal conversations with residents served to build rapport and help formulate the wording of the open-ended interview questions. For example, broad consensus (and preference) for the term ‘wellbeing’ rather than ‘health’ and/or more technical terms such as coping, resilience, became apparent and therefore subsequently utilized. This co-production of knowledge and joint ‘meaning making’ was central to the analysis, outlined below, and adopted methodology.

Open-ended interviews were chosen as the primary method of data collection, allowing participants to talk freely and subjectively. The opening question asked ‘how would you describe your wellbeing whilst living here’ was followed up by questions such as ‘How would you describe the feelings of wellbeing most familiar to you in here?’, ‘Have you experienced wellbeing within every-day events?’, ‘What are the feelings you most often have as a resident related to your wellbeing?’ ‘Would you say you have had experiences that bring you in control of your wellbeing?’ An emergent design was adopted, allowing for adaptations in questioning, drawing out participants subjective accounts of wellbeing, as they emerged through dialogue, with personal and social meaning and closely associated with the environment as discussed in the findings. Data were collected over a 3-week period. The duration of interviews ranged between 30 and 70 min (mean 45 min). Brief field notes were kept by the PI and used to explore and check meaning-making (Kvale, 1996; Malterud, 2001; Creswell, 2003) both with participants in subsequent interviews and also co-authors. All interviews were conducted on-site at the convenience of participants, and recorded, fully transcribed and exported into NVIVO v 2.0 (QSR, 2000) for data organization, management and retrieval.

Data analysis
The process of coding and categorizing was conducted in two phases. In the first phase of the analysis participant’s accounts of wellbeing were transcribed and themed first in relation to their experience of wellbeing while homeless. This approach follows Grbich (2007), whereby homeless peoples’ attitudes and meaning structures around wellbeing are explored (constructivist approach) through an understanding of their everyday lives. This first phase was guided by principles of ‘Framework Analysis’, which provides a systematic and disciplined, yet creative and conceptual process of determining meaning, salience and connections in qualitative data (Ritchie and Spencer, 1994). Framework analysis consists of five key stages (i) familiarization with the data; (ii) thematic analysis, based upon constant comparative technique of coding and
developing and testing emergent themes, resulting in an emerging framework; (iii) material is sorted and indexed under themes and subthemes; (iv) charting to build a picture of the data as a whole, showing the data ‘lifted’ from its original context to a thematic reference and ‘charted’ within the framework and (v) mapping and interpretation enabled the key characteristics of the data to be drawn together and be interpreted as a whole.

For the second phase in the analysis fragments of transcripts were categorized according to the Salutogenic approach and theory. This resulted in four groups of fragments with the labels: (i) internal GRR (ii) external GRR (iii) manageability and (iv) meaningfulness. Fragments of comprehensibility were not found in the data. Quotes provided in the findings sections are selected to be representative of interviewees’ reactions and experiences as reflected in relation to that specific category.

Reflexivity
From the outset the team was aware of the potential power imbalance between researcher and researched. Within a constructivist approach, the PI endorsed a reflexive viewpoint (Barry et al., 1999; Olesen, 2007) when interacting with residents, acknowledging co-construction of data and meanings and therefore the acknowledgement of potential power imbalances that may misrepresent and inappropriately privilege certain perspectives over others (Gergen, 1999; Charmaz, 2006). As a volunteer at the hostel (1 month, <10 h/week), the potential influence of the PI’s perceived role on the research relationship was appreciated from the outset and the study was conducted with this in mind.

FINDINGS
Thematic analysis resulted in the broad thematic groupings of factors supporting wellbeing shown in Table 1. Wellbeing relates to (i) beliefs of recovery and renewal of self-confidence (ii) the ability to use personal and/or external resources such as social skills or problem solving (iii) in accounts valuing numerous or continuous personal participation and dependent on (iv) a number of mediators such as daily stress or boredom (see Table 1).

Table 1: Thematic grouping of factors supporting wellbeing

<table>
<thead>
<tr>
<th>Grouping of Factors</th>
<th>Types of Effort Made</th>
<th>Resources/Resourcefulness</th>
<th>Mediators</th>
<th>Participation and Esteem</th>
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<td>1.0 Beliefs of recovery and renewal of self-confidence</td>
<td>1.1 Beliefs of recovery</td>
<td>2.0 Resources/Resourcefulness</td>
<td>4.0 Mediators</td>
<td>3.0 Participation and Esteem</td>
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<td>1.1 Beliefs of recovery</td>
<td>1.2 Types of effort made</td>
<td>2.1 Staff</td>
<td>4.1 Opinions/beliefs</td>
<td>3.1 Learning and helping others</td>
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<td>1.2 Types of effort made</td>
<td>1.3 Positive thoughts, seeds of ideas, worked ideas</td>
<td>2.2 Ways of problem solving</td>
<td>4.2 Boredom</td>
<td>3.2 Contributions</td>
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<td>1.3 Positive thoughts, seeds of ideas, worked ideas</td>
<td>2.3 Initiative</td>
<td>2.4 Social skills</td>
<td>4.3 Daily stressors</td>
<td>3.3 Something to show/recognition</td>
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<td>2.0 Resources/Resourcefulness</td>
<td>2.4 Social skills</td>
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<td>3.4 Give something back (reciprocity/positive contributions)</td>
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<td>2.1 Staff</td>
<td>3.5 Positive effects/feeling better (positive) about self</td>
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<td>2.2 Ways of problem solving</td>
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The second step in the analysis of the interview data and field notes revealed that the situational interpretation and meanings of wellbeing amongst participants here are contingent within beliefs of a sense of control and associate with Salutogenic concepts of internal and external GRRs and manageability and meaningfulness (elements of SOC). The following findings are illustrations of these four groups of fragments.

Internal GRR: recovery and renewal of self-confidence from understanding the need for change
Central to participant’s accounts of homelessness were their personal stories around recovery, grounded in a conscious or ‘comprehensible’ need for change. Central to this were beliefs of control over the situation which resonate with internal GRRs:

...there’s a point... you need to take a step back and err you know think of things more objectively ... stand up for yourself and, and not be blinded (Interview 4/33: Paul)

One participant gave an account of their personal story of recovery, grounded in a conscious need for change:

it’s been quite good and refreshing to be honest, yeah I’m listening to other peoples suggestions
and thoughts – before I was quite (…) comparing now with, whether it be 2 years or 6 years ago or 8 years ago, (…) (Interview 1/70: Jon)

Across cases, more divergent accounts of well-being were expressed such that self-confidence was strengthened through sustained effort, personal persistence and having a meaningful purpose in life (getting a job, having your own house):

So I mean, I’ve gone from being redundant, separated, homeless (…) I’m starting a brand new job and hopefully in the next couple of months or so I’ll be out of here as well. It’s gone totally round you know. (Interview 3/14: Jeff)

External GRR: resources and resourcefulness from formal and informal support

GRRs such as accessing professional advice and peer networks combined with internal resourcefulness (taking the initiative, seeking help) strengthen wellbeing. A range of practical and emotional resources associated with promoting wellbeing were evident in conversations, for example in-house sessions (therapy, counselling and stress-relief sessions) with other support from less obvious sources:

[…] even the security staff, they will listen to you, you know. It’s got a sort of ambiance about the place where if you have got an issue there is always someone who can help you out with it. (Interview 3/19: Jeff)

One important role clearly identified for staff was conflict resolution:

yeah…you can obviously, put in a complaint if you have a problem but you can always talk to the staff they’re good at resolving issues – something comes up err…

They’re systems in place here – there’s people here that are just ‘gold dust’ you know, if they weren’t here things would be a lot worse…

(Interview 4/28: Paul)

Some participants justified their move into temporary accommodation as not only a response but also as a resource to a crisis situation:

…she still kept coming round every day so I couldn’t get away from it all drugs, alcohol, trouble, cause I had no control over who came into the house (…) so when I came in here the things they give me was privacy you know ‘that was the door’ (…) so who I wanted in my, I was like that (strong hand gesture – stop). So to come here’s been really good for me – really good, been nothing but good, nothing but good. (Interview 5/10: James)

Manageability: as an element of ‘control’ over the situation

Accounts above described internal and external GRRs, potentially suggesting how this positively directs movement towards greater control over the situation and manageability, which could potentially enhance wellbeing.

One participant described their residency as their ‘solace’ (escape) in terms of a co-dependency or abusive relationship. Another described how temporary housing was critical, in terms of resourcefulness, in enabling her to maintain and normalize family and social relationships:

they’re a bit shocked I’m in here – ha, ha, ha, – course especially my Son cause he says you know you’re my Mum, you know you shouldn’t be in a (accommodation) project – but it’s my solace you know, I’ve got independence and I can come and go as I please. (Interview 6/38: Charlotte)

Participants believed self-esteem to be strongly associated with wellbeing and this in turn is tied in with developing appropriate resistance to the social stigma attached to people living in temporary accommodation. Moreover, because living in temporary accommodation is stressful and is exacerbated by other resident’s behaviour, a certain tolerance of others is important:

Some tow rag wants to, you know err want to bump in front of you to have a game of pool and you’re the next down, you have to stand up for yourself…tell them where to get off and stuff like that (Interview 4/19: Paul)

Whereas some felt it necessary to avoid doing too much for others:

I just don’t go round as an agony aunt, I don’t wanna get involved with all their problems and I don’t want that so – kinda stay clear…(Interview 6/21: Charlotte)

For many remaining occupied can be a major problem, especially for those who are socially isolated or unemployed, for others it’s a way of avoiding trouble:
It’s boring in here because I don’t associate and of an evening I’m just in my room and that’s it. I don’t drink err I just sit and watch TV. It’s less trouble and you can’t get into any trouble of a night time. (Interview 5/40: James)

Others, however, were better at occupying themselves, maintaining personal relationships and accessing in-house resources (therapy, counselling, stress relief, staff, internet, etc.) and maintaining personal interests was considered critical for wellbeing:

If I get fed up or I get depressed I just go and I’m out, gone, find something to do… that’s all you can do isn’t it… If you sit in a corner and sulk all day it’s doing you no good is it, you get more and more depressed – more and more anxiety… (Interview 8/15: Dan)

Some more than others were better at organizing time constructively:

There’s excellent facilities here you know, you’ve got the internet which is great cause the boredom does set in very quickly. (Interview 4/15: Paul)

As one man explains he’d rather be occupied with a personal interest than sit about:

I’d sooner go out for a walk… go bird watching or something like that again it’s just boredom there’s nothing to do of a day – well in here… (Interview 8/72: Dan)

Those who continued to maintain personal and family ties found it easier to manage difficult situations:

Now if I’ve got an issue or a personal problem like, it’s my Sister, she is my Mum basically like you know, well, I mean my Mum’s my Mum obviously but my Sister is like sort of a twin if you like (Interview 3/12: Jeff)

Not all social interaction, however, is positive for wellbeing. For some it was necessary to be selective of the company they kept, especially where addiction and co-dependency was an issue:

Yeah lots of times with the relationships I was in for err example the person involved was a big drinker and err there was quite a bit of denial it was affecting their head, there’s a lot of people with that trouble but I’ve been no exception (Interview 4/19: Paul)

Meaningfulness: as part of a meaningful contribution to society

For most participants, improved sense of wellbeing was expressed through social participation; ‘giving something back’ or bringing meaningfulness with inclusion in regular activities being central to discussions:

I’ve got off the drugs, I’m on the committee, I teach a classroom… to the young kids here, and for the rest of the week I teach cookery here for the young kids as well… (Interview 5/10: James)

Residents who have opportunities to engage in project activities, especially working for the benefit of other people, felt a greater sense of purpose, belonging and meaningfulness in otherwise chaotic lives:

I’ve something to show for it (award), err, you get a bit of recognition for it which I like, you know. I like to meet other people who are in here and you realise you’re not quite so alone… there are other people going through it. (Interview 1/53: Jon)

Some seek out opportunities to make a meaningful contribution to society, being occupied or helping themselves:

Err moved in, got to know people, sort of wanted to get involved in certain things, like I’ve just started a football team, err liaising with the staff trying to get some kind of employment help… (Interview 3/08: Jeff)

Helping others was an important theme. Reciprocity was illustrated in terms of feeling conscientious and having empathy or respect with others, resulting in positive self-worth:

I get a lot of joy knowing I can have a positive effect on younger people… cause they are very open to influence whilst they are in here, so if you can get some good influence into them… it makes me feel good anyway it makes me feel better about myself it gives you a goal as well, the things I do give me a reason to get out of bed really otherwise you know I could just stop in bed and fester but you know you find yourself things to do, positive things to do… . (Interview 5/37: James)

These finding illustrate available internal and external GRRs and the way homeless people use and re-use these to resources influence their wellbeing whilst in temporary accommodation. We have focused purposefully on empirical
DISCUSSION

We are unaware of previous studies using people’s expressions of wellbeing to explore Salutogenic theoretical terms SOC, and GRRs in the context of homelessness within industrialized society. The approach is unique in that it demanded environmental and personal sensitivities to people living in temporary accommodation and reconciliation of theoretical approaches. A particular strength of this study includes the emergent style of inquiry-facilitated access to personal areas of participant’s lives, through a reflexive process of building trust and mutual respect through informal engagement in the research context over time. Familiarity of the PI with the research setting and the social context of the study following volunteer work is, however, both a strength and limitation. Although rapport may have been facilitated or enhanced by insider knowledge, this may also have compromised the accounts offered by some or all participants. Whilst possible influence on credibility and trustworthiness of the data is acknowledged by the authors, inherent awareness of this from the outset and inherent reflexivity of the study design, including discussion throughout with second author, may provide reassurance. From a constructivist paradigm the authors acknowledge that all research is potentially bias; all knowledge is partial and co-produced. Notwithstanding this, our methodology and analysis is distinct from approaches previously reported from cross-sectional studies involving validated SOC questionnaires focusing on development and changes in SOC. This qualitative study purposefully explored those properties said to be supporting wellbeing and empirically explored ‘how’ movement towards the health end of a health ease/disease continuum might occur; a strength featured in similar empirical work (Lezwijn et al., 2011).

Our findings suggest that beliefs of recovery, accounts of renewed self-confidence, perceived resourcefulness and continual personal participation can usefully illustrate the GRRs fundamental to the Salutogenic perspective reported by Eriksson (2007), and are worth considering. Caution is advised here as research on situational resources also report properties considered ‘protective’ as well as internal/external resources (Antonovsky, 1987; Eriksson and Lindstrom, 2005; Harrop et al., 2006; Lezwijn et al., 2011).

A diverse range of personal experiences expressing recovery and renewed self-confidence and beliefs of a conscious desire for change were found. Lay terms for this are ‘listening to advice’, ‘thinking more objectively’, ‘understanding change and, more generally, having an awareness of the need for strategies that improve one’s personal situation and enhanced sense of wellbeing.

In the context of risk, stress and wider coping theory (Harrop et al., 2006) resilience is a concept related to SOC because it deals with coping with adversities. However, the starting points are completely different. While Antonovsky refers to a positive outcome independent of stress under certain conditions, research on resilience starts by recognizing the risk for a negative or pathogenic health outcome (Lindström and Eriksson, 2010). Further, resilience implies exposure to adversity and manifestation of positive adjustment experiences (Luther and Ciccetti, 2000). Contrasts were apparent to the resilience theory and uncovered as conditions of tenancy require regular assessments for future independent living. Here we found staff professionalism strongly connected to accounts of movement in the Salutogenic direction, and not personal accounts of resilience, to be key enablers of recovery.

This study supports the notion of SOC. Part of participant’s ability to move in the Salutogenic direction came about from positive experiences of being listened to by staff who responded quickly to issues. These are seen in lay terms, being ‘someone who can help out’ and by ‘resolving issues’ and acting as external resources when facilitating the navigation of institutional or bureaucratic systems for residents. Day-to-day dealing with uncertainty and stress is important to wellbeing and interestingly strengthening SOC this way may positively influence future levels of ‘distress. Lay accounts of SOC, however, are less prominent here, given participants’ adverse circumstances; this may have been influenced by the focus on properties supporting wellbeing, not risk reduction. Strengthening of SOC is apparent with increased interactivity (situational), between participants and staff, enhancing the mediating effect of problem solving mechanisms at the community level, supporting previous findings (Wallerstein, 1992). The important role played
by institutions which afford participation opportunities has already received considerable attention (Harrop et al., 2006; Wright and Tompkins, 2006; Lezwijn et al., 2011).

As noted SOC has a motivational component, described as meaningfulness (Antonovsky, 1979). Being motivated to give something back or make a contribution is shown to support wellbeing. Interestingly coping and resilience literature focus less on motivation and more on managing distress and risk in relation to person and environment (Eriksson, 2007). Motivation in lay terms was evident in beliefs such as I've something to show (life-experience, skills) and I can work it out for them; motivation for one homeless participant means enjoying the positive effects of both his participation and being with like-minded young people, he stated emphatically—they're about you. Similarly, the literature on coping reports the positive and negative qualities of close relationships and the meaningfulness of these relationships (Sarason et al., 1997).

Cognitive theories of stress and coping are criticized (Antonovsky, 1987) for making assumptions that life is in balance and disturbances damage health and wellbeing (pathogenic viewpoint). Experiences counter to wellbeing were frequently and consistently expressed alongside movement towards wellbeing as the norm. We found that collectively participants expressed beliefs of a deep awareness and concern for their own and others high-risk (chaotic) lifestyle choices and behaviour both before and during the study. Given this fact cognitive theories (Lazarus and Launier, 1978) may better account for psychological suffering from depressive states including boredom as this was counter to wellbeing in all cases. We discovered educational activities, social opportunities and staff professionalism were key beneficial resources to deal with the daily problems (including boredom) inherent to homelessness. More research is needed to unpack and assess the effectiveness of structured and professional-led interventions on a wider scale.

As articulated throughout, the definition of wellbeing is highly subjective. Antonovksy had concerns about investigations on wellbeing; he defined wellbeing differently from health and indeed, reporting concepts like wellbeing and other dimensions of life satisfaction have different theoretical basis (Eriksson, 2007). Wellbeing as we are aware does not have an agreed definition (SDRN, 2005) and is therefore subject to interpretation bias for example ‘mental health and wellbeing’ and associated terms such as ‘quality of life’, previously linked with SOC (Lindstrom, 1992). We, however, found the distinction between health and wellbeing academically founded. We were interested in exploring homeless people’s beliefs around their own wellbeing and so started from the premise that they themselves will have their own definitions and that these are socially situated. Wellbeing is a broad and subjective concept; from a lay perspective, ‘wellbeing’ is potentially a holistic concept and therefore is found here useful for describing SOC.

CONCLUSION

In utilizing a Salutogenic perspective of health, we demonstrate how the ‘context and meaning’ of health actions, and the determinants that keep people healthy, can improve the understanding about the kinds of factors influencing positive wellbeing in people who are living in adverse circumstances. Highly polarized accounts emerged of lives as chaotic, anxious and stressful. A strong belief in their own and other sources of help was a critical enabling factor for those living in temporary accommodation. Wellbeing was consistently linked with both social and formal activities; keeping occupied and having a strong sense of purpose were essential to wellbeing. Empirical studies suggest that those with a strong SOC are likely to identify a greater variety of GRRs at their disposal. This has practical and political implications for the future planning of on-site resources, as health services play a minor part in coping with extreme levels of stress and anxiety on a daily basis. Our study suggests educational activities, social opportunities and interaction with professionals as beneficial resources to deal with daily problems. UK economic challenges and recent policy changes (Ministerial Working Group on Preventing and Tackling Homelessness, 2012) require local government (social) and health services in England to collaborate closely to deliver improvements in public health through Health and Wellbeing Boards. While more research is needed to unpack and assess the effectiveness of structured and professional-led interventions in enhancing the wellbeing of the homeless on a wider scale we suggest that agencies and professionals
themselves should rethink assumptions about the homeless and adopt practical approaches that enable clients to recognize and mobilize existing assets and resources (personal and structural) that will move people towards a greater sense of wellbeing.

Antonovsky described SOC within a ‘global’ orientation. This study has relevance as acquiring resourcefulness for facing future adversity and feeling connected through participation meaningfully with others enhances wellbeing. Wellbeing for the most part in temporary accommodation is understood as situational-coping strategies combined with self-determined actions.

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