

## A Sense of Family Coherence, Formation of Health and Health Behavior – A Discussion Starter

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### Introduction

Stressors are more likely to be associated with crisis-like courses that can lead to illness. However, when resources are used flexibly, they can also stimulate developmental processes and contribute to health literacy in its broadest sense. Recognising such “positively deviant cases” motivated Aaron Antonovsky [1] to write his ground breaking work “What Keeps People Healthy?” According to him, the repeated experience of successfully managing crises is reflected in an inner structure (“sense of coherence”). This refers to a fundamental confidence that one’s actions are worthwhile, that one is valued and heard as a valuable member of a community (“sense of meaningfulness”), that the social world follows fundamentally comprehensible rules (“sense

of comprehensibility”), so that one can find one’s way even in new situations and, on the whole, cope with difficult situations, alone or with the help of others, (“sense of manageability”). Antonovsky posited that a strong sense of coherence enables a more targeted and flexible use of available resources and thus a better organisation of daily life (including explicit crisis management), which has been confirmed in various areas of life and is particularly significant with regard to living with chronic illness and health promotion [2]. Understanding the sense of coherence not only enriches theoretical perspectives but also provides clinicians with a practical framework for recognising and supporting patients’ coping resources during family medicine

consultations, making care more attuned to patients' lived experiences.

The extent of this confidence varies with available resources and the quality and quantity of past experiences of success. The sense of meaningfulness results from the experience of opportunities for participation and belonging; the sense of comprehensibility from the experience of consistent processes and interactions; and the sense of manageability from the experience of a balance of stress commensurate with one's own capabilities. The sense of coherence develops throughout one's lifetime, with early childhood experiences carrying particular weight: the formation of health initially (and primarily) takes place within the nuclear family. The fundamental structures can only be internalised if they exist [3]. In familial interaction, experiential spaces are provided that enable (or hinder) the development of the sense of coherence. In this way, the individual simultaneously grows into a life orientation that characterises the family system as a whole—one that is rarely fully conscious to those involved but reflects the group's sense of belonging. Antonovsky had already described the idea of family coherence. Some research shows that family members often have similar SOC levels. Yet, few studies examine shared family views. This is partly because it is hard to measure a family's overall perspective. Vossler [4] explains that Family Sense of Coherence (FSOC) may focus on family life or on the family's broader worldview. FSOC can be measured at the individual or family level. The main problem is how to capture the group's view: should we use average survey responses, or give more weight to strong views, such as those from family leaders or from people who disagree with most others? These

open questions in research methods should be explored in small, pilot studies.

Reflecting on the respective sense of family coherence is worthwhile for the theory and practice of family medicine-oriented general practice. In long-term care, the more direct insights into family life become possible, the more deeply physicians develop a sense of each family's worldview. To date, the impression of the family's worldview remains implicit among physicians, patients, and their families, yet it continues to guide their actions. I would like to illustrate this using the example of Review Dialogues (RD) [5,6]. Several extended conversations were conducted with patients with chronic conditions to identify, based on a shared assessment of their current life situation, the health goals most important to them and those that should be achieved within a foreseeable timeframe. These goals could be chosen independently of the chronic conditions, and it became apparent that they were oriented much more strongly than doctors had expected toward fundamental life goals and life-stage-related requirements. The RDs were accompanied by a broadening of perspectives and helped clarify family patterns of interpretation and rules.

### **Case Study**

A 35-year-old woman of Turkish descent, raised in Germany, has been under the care of her primary care physician for over 10 years. During the RD, she complains of high blood pressure, palpitations, fatigue, exhaustion, and mood swings, symptoms that have been present for years and are difficult to manage. She holds a responsible administrative position. She is married to a man who grew up in Turkey; the couple has two school-age children. The

patient torments herself with self-reproach for not being a good mother. The family doctor is well acquainted with this set of problems; a convalescent stay for mothers and psychotherapy were initiated years ago and appeared to have been helpful. The cardiological evaluation yields no findings. In a subsequent consultation, the family doctor offers a psychosomatic explanation, which the patient vigorously disputes. Further exploration reveals an unresolved marital crisis, as well as the fact that the patient finds no support within her social circle. She is unable to assert her more liberal views and her desire for her own social contacts, and sees herself as an outsider. The doctor encourages her to actively advocate for her interests and to clarify her primary goals (separation or a fresh start?). The patient decides on a fresh start, is better able to realise her own wishes, and thus experiences appreciation and recognition independent of her family. During a joint vacation in Turkey, she discovers that her husband, too, is distancing himself from traditional notions, and after 15 years of marriage, they find a shared sense of identity. "We're both Deutschländer, after all." Although the doctor was well-informed about the patient's situation from her long-term care, the underlying differences regarding (culture-specific) values had not yet been addressed in their former consultations. Circular questions about how the children, the husband, or even relatives and friends assessed the situation enabled the patient to tell the story of her marginalisation and to feel taken seriously and valued by the attentive listener. It became clear that the patient had been forced to assume the role of the sick and had now, years later, found help. Through the (mental) inclusion of significant others, the role of the support system became clearer and was also influenced. The

physician observed a significant strengthening of the patient's salutogenic resources and felt a greater sense of relief herself.

The term "Deutschländer" was coined by the patient herself—the correct term would have been "Germans." However, the term she chose aptly describes her sense of identity.

While this example concerns a family negotiating between Turkish and German cultural expectations, its insights are broadly applicable. Many families, regardless of cultural background, encounter tensions between individual needs and shared family or societal values. The process of openly addressing value differences and including the perspectives of significant others can help uncover hidden sources of stress, strengthen coping resources, and foster a stronger sense of coherence within the family. Clinicians working with families from diverse backgrounds may consider similar approaches to facilitate communication, validate experiences, and support the development of shared health goals. This case may serve as a starting point for reflecting on the importance of cultural and relational factors across a variety of family and community contexts.

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