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A salutogenic strengths-based approach in practice – an illustration from a school in Sweden

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**ABSTRACT**

Despite an extensive debate and an openness of teachers to a strength-based approach to health and physical education, it is not always clear what a salutogenic strengths-based approach might look like in practice, at least not in the day-to-day work in schools. The purpose of this article is to present a salutogenic strengths-based school initiative in Sweden and to identify health discourses in the school’s practice. An insider perspective is used to explore health in the school through Brookfield’s four lenses for exploring one’s own teaching practice. Two health discourses are identified: (1) an individual health discourse rooted in the fostering of personal development, and (2) a value-based health discourse build up around social relations and the fostering of democratic values. The individual health discourse can be understood as based in a pathogenic norm, and in the investigated school practice the individual health discourse dominated the school health initiative despite the salutogenic intentions.

**KEYWORDS**

Salutogenesis; health education; physical education; practice

**Introduction**

In many respects, national school curricula convey the political intentions for education (Ball & Bowe, 1992), and can be regarded as authoritative educational documents understood as on-going struggles over the content of education (Englund & Quennerstedt, 2008). Physical education (PE) curricula thus mirror existing health discourses and interests in contemporary society such as preventing physical inactivity, but also the opposite is possible where notions of health in PE can impact health and health education in school in general. One example of this is how health information given to students potentially reaches their families, and in this sense, PE as a school subject becomes an interesting arena for various public health initiatives like increasing physical activity levels in the population.

Scholars have internationally recognised the difficulty of realising policy outcomes in PE practice (e.g. Brown & Penney, 2013; Macdonald, 2013; Penney, Brooker, Hay, & Gillespie, 2009), and when wider notions of, for example, health are introduced in...
policy the gap between policy aspiration and school practice is obvious. That this can be the case, can be illustrated by curriculum reforms in Australia, New Zealand or Sweden (Macdonald, 2013; Quennerstedt, Burrows, & Maivorsdotter, 2010; Renwick, 2017) and in this transformation of policy, we would argue that Australia is of particular interest since the deliberation and political compromise that has resulted in the Australian National Curriculum in Health and Physical Education (HPE) (ACARA, 2012, 2013) has (from an outsiders’ perspective such as ours) resulted in a national curriculum with unprecedented potential. To be clear, HPE in Australia is not the same as PE in many other countries. In this paper, PE is used to talk about the school subject area in general which in Sweden is called ‘idrott och hälsa’ (Physical Education and Health, PEH). In Australia, however, the school subject health and physical education (HPE) is much wider including the strands ‘Personal, social and community health’ and ‘Movement and physical activity’ where the latter strand in many ways corresponds to PE and PEH.

Regarding the educational content of HPE, there has been a noteworthy and extensive discussion in Australia about its direction, with a particular emphasis on the shaping and implementation of the Curriculum (e.g. Brown, 2013; Brown & Penney, 2013; Hickey, Kirk, Macdonald, & Penney, 2014; Lynch, 2014; Macdonald, 2013; McCuaig, Quennerstedt, & Macdonald, 2013). This is an apt example of an on-going struggle over the content of education as described by Englund and Quennerstedt (2008, for an overview from Australia, see, for example, Alfrey & Brown, 2013; Dinan-Thompson, 2013; Lambert, 2018; Leahy, O’Flynn, & Wright, 2013; Macdonald, 2013, 2014). One of the important consequences of the implementation of the AC:HPE is a shift from a pathogenic (i.e. a deficit and risk-focused perspective of health) to a salutogenically grounded strengths-based approach with a focus on health resources students develop in HPE (McCuaig et al., 2013). This shift regarding what health is, or can be, within the context of HPE is not dissimilar to the approach taken in countries such as Canada, New Zealand or Sweden (Quennerstedt et al., 2010; Renwick, 2017). In Australia, Lambert’s (2018) study, for example reveals that teachers’ considerations of health ‘have shifted to thinking more about assets, capabilities and resources of young people as opposed to more traditional deficit, risk models or views of them’ (p. 136). Despite the extensive political debate, and the openness of teachers to a strength-based AC:HPE, it is not always clear what a salutogenic strengths-based approach might look like in practice, at least not in the day-to-day work in schools (see also Alfrey & Brown, 2013; Dinan-Thompson, 2013; McCuaig et al., 2013).

This paper seeks to address that lack of clarity, and like in Australia, a broader notion of health was identified several years ago in the Swedish PEH context (Quennerstedt et al., 2010). Initiatives have, for example, been taken into schools around Sweden encouraging them to become ‘health promoting schools’ and in this paper, we present one such initiative. We do this in order to shed light on the ways in which health discourses shape, practice and how they are grounded in pathogenic and salutogenic notions of health. In this paper, we will try to create a dialogue between the Swedish and the Australian context giving strength to the conclusions made in this paper supporting a more general understanding of the findings.

We begin by firstly presenting the work done around health in a wide sense in one Swedish school for more than 10 years with children 6–12 years old. The first author of this paper worked in the school as a PE-teacher, and was a project leader for a whole
school venture called ‘Health and learning in ensemble’. Second, a practice-oriented study of this school is presented and a salutogenic strengths-based approach is explored with particular emphasis on how it can unfold in practice. Throughout this study, Brookfield’s (1995) four lenses of reflective practice are employed by the first author to explore his own practice. These lenses are used alongside discourse analysis (Phillips & Jorgensen, 2002) in order to both explore health education from ‘the inside’ (i.e. seeking to become a critically reflective teacher) as well as scrutinizing the same practice from ‘the outside’ (as external actors in the development of this project). The purpose of this article is accordingly to present a salutogenic strengths-based school initiative, and further to identify health discourses in the school’s practice. The results will also be discussed in relation to a salutogenic strengths-based approach to health in school.

**Background**

Health education in school can be conducted in different ways and the content as well as the teaching of health education depends on the assumptions that exist and are valued around health (Leahy, Burrows, McCuaig, Wright, & Penney, 2015; McCuaig et al., 2013). Schools have, for a long time, been seen as an arena for political debate regarding health. In the main, this is because schools are places where young people are easy to reach and where, at the same time, it is possible to reach into family homes with messages regarding health (Quennerstedt et al., 2010).

In Sweden, a wider health perspective was introduced in schools during the last three decades of the twentieth century, (Quennerstedt et al., 2010) in terms of a shift from the prevention of risk and disease towards the strengthening of health including aspects of democracy and societal values. The introduction of the 1994 curriculum in Sweden entails a break from health being regarded as a purely physiological matter to a view of health described as different aspects of well-being (Quennerstedt et al., 2010). Health is here defined as: ‘… physical and mental health, as well as social well-being’ (Quennerstedt et al., 2010, p. 2), and Quennerstedt et al. (2010) argues that the shift in the curriculum is not only directed at individuals but also towards student capacity to influence the development in society in general. This shift is clarified but also slightly more individualised in the current 2011 curriculum for PEH in Sweden where issues of life-long health, different perspectives of health and a focus on how students should be given the opportunities to reflect on and take a stand on issues relating to lifestyles and health (Brolin, 2014). However, the shift in both curricula (1994 and 2011) also includes an individualisation of health in which the individual is expected to take responsibility for their health and make the ‘right’ healthy choices in order not to be a burden on society. In this sense, health as an individual endeavour becomes something that schools should deliver, and something students should adhere to and, as responsible citizens, embrace (Brolin, 2014; Leahy et al., 2015).

In PE several scholars argue that health is strongly influenced by its relation to pathogenic obesity discourses and that this influence limits what can and should be done in the name of health (e.g. Quennerstedt, 2008a; Sinkinson & Burrows, 2011). In this vein, Gard and Wright (2001) argue that PE’s efforts ‘to legitimate itself on the basis of claims about obesity and overweight […] are not only shaky but ethically irresponsible’ (p. 537). In an Australian context, McCuaig (2007) asked: ‘Why do schools fail to conceptualize the
whole child, marginalizing those issues emanating from the physical, emotional and spiritual? (McCuaig, 2007, p. 282). Much in the same way as the critical research presented above, McCuaig (2007) criticises the narrow notion of health in Australian schools and advocates for a health perspective that places the whole person at the centre. Taking a historical perspective, McCuaig and Hay (2013) argue that HPE has been framed within certain principle positions; namely, that healthy citizenship comes with individual responsibility for health and, as such, HPE can be seen to take a pathogenic position. In challenging the status quo, McCuaig and Hay (2013) advocate for a salutogenic understanding of health, where resources for health rather than deficits and risks are highlighted. Unsurprisingly, this is the route Australia, through the AC:HPE, has embarked upon (Brown, 2013; Hickey et al., 2014; Macdonald, 2013; McCuaig et al., 2013).

A salutogenic strengths-based approach

The basis for the AC:HPE – as well as the health initiative of the investigated school – is a salutogenic approach to health (Antonovsky, 1996; McCuaig et al., 2013; Quennerstedt, 2008a). Salutogenic perspectives, as Antonovsky (1996) reminds us, have emerged as a critique of predominantly biomedical (so-called pathogenic) notions of health. A salutogenic perspective instead takes its point of departure from a different philosophical standpoint (McCuaig & Quennerstedt, 2018). A common critique is then a resistance towards health defined in a dualistic manner as the opposite of disease or not normal behaviour (Mittelmark et al., 2017). Antonovsky formulated this critique as:

If one is 'naturally' healthy, then all one has to do to stay that way is reduce the risk factors as much as possible ... [and] ... facilitate and encourage individuals to engage in wise, low risk behaviour. (Antonovsky, 1996, p. 13)

From a salutogenic perspective, health is not something you either have or do not have. Rather, health is about different degrees of health and can be seen as sitting on a continuum created and sustained in an on-going process between ease and dis-ease (Lindström & Eriksson, 2010; Quennerstedt, 2008a). In this vein, everyone is in some way always healthy, and many aspects that promote or prevent health development are encompassed. Diseases can, from a salutogenic perspective, affect people’s health but are regarded as separate processes applicable in certain situations as something that hinders health development. In this way, health is created in an interplay between individuals and the environment. In other words, we need to look for different origins and resources of health in order to understand health in education from a salutogenic perspective (McCuaig & Quennerstedt, 2018).

Method

The setting for the study is a school situated in a rural area the middle of Sweden just outside a major city. At the time of the study, the school had just under 200 students between the ages of 6 and 12 years old and a total of 30 staff. About 15 years ago the school started an initiative regarding health in a wide sense; a health initiative which, in many senses, can initially be described as a preventative health effort moving over time towards a salutogenic strengths-based approach. It began as a project where municipal
funding had been allocated to health in different work places where the number of employees on sick leave was high. The goal of the initiative was to create something ‘healthy’ for the staff and the task was handed to the PE-teacher (the first author). At the time the PE-teacher had a leading role at the school and was also teaching social sciences.

In this paper, an insider perspective was used to explore the approach to health taken in the school. Particularly, Brookfield’s (1995) four lenses (the narratives of the teacher, the students and the colleague as well as a theoretical perspective) for exploring one’s own practice was used. The narratives collected were: 9 autobiographical narratives from the teacher (the first author), 1 narrative from a colleague, and 20 narratives from students aged 12 at the time of data collection. The initial ambition of the study was that the teacher’s autobiographical experiences, together with the students’ and the colleague’s narratives on the issue, would contribute to a better insight and comprehension of the investigated practice. The second ambition was to explore the narratives from an outsider perspective (i.e. the other authors) using theory. Brookfield describes this fourth lens as follows:

… we can view our practice through the lens of literature. We can read inside and outside our area of practice, to locate what we do within alternative theoretical frameworks. (Brookfield, 1995, preface, p. 13)

Brookfield (1995) here reminds us about the possibility to look from within as well as from outside of the investigated practice with the help of theory. To this end, we chose discourse theory and analysis. The reason for the choice of discourse theory as our analytical tool was because it can help teachers (such as the first author) to distance themselves from their own practice, as well as making it possible to discern what the narratives reveal in a wider perspective in terms of discourses (Gee, 2014; Phillips & Jorgensen, 2002).

**Narratives and thematic analysis**

Research using narratives evolved, according to Goodson and Numan (2003), as an ambition to better understand human behaviour and action. By taking part of people’s lived experiences in narratives, where actions and meaning is put into word, we can, according to Polkinghorne (1988), explore memories, thoughts and people’s meaning-making. In this tradition, life-stories are narratives that can be seen as separate sections in the experiences of the narrator, and in our study, the narrative of the teacher can be described as autoethnographic while the narratives from the colleague and the students might be described as life-stories.

According to Brookfield (1995), one of the advantages of an autoethnographic lens is that it puts the narrator, in this case, the teacher and first author, in the role of the other. In othering ourselves, we are able to view our own practice from the other side of the mirror. On the other hand, as Brookfield argues, ‘The intrinsic problem with approaches to self-reflection is that when we use them, we can never completely avoid the risks of denial and distortion’ (Brookfield, 1995, p. 33). In this vein, Brookfield’s lenses were crucial in order to avoid this distortion, and in hindsight, the student narratives and the theoretical lens particularly fulfilled the purpose of critiquing the PE-teacher’s taken for granted assumptions.
The teacher wrote nine extensive stories about his work around health in the school. Each story deliberately contained a beginning, a middle section and an ending. This allowed the teacher to follow a certain chain of events to a conclusion. While it is acknowledged that experience is both continuous (i.e. it builds on other experiences over time) and interactive (they mingle with the sociocultural environments in which we live) (Casey, Fletcher, Schaefer, & Gleddie, 2017) bringing each experience to a conclusion allowed the first author to mediate his experiences into a story which could then serve as ‘a portal, a window, into how individuals understand their own experiences’ (Casey et al., 2017, p. 29).

The students’ narratives were written as essays in the school subject ‘Swedish’. In these lessons, students were asked to retrospectively look back on their 6 years of participating in the school’s health initiative. Twenty students in grade six (age 11–12) wrote essays. Brookfield (1995) argues that students are an essential lens if teachers are to see their own practice in a new light. However, there are risks with this. Both Casey and Schaefer (2016) and Brookfield (1995) describes the difficulties regarding honesty in the student narratives: ‘The main difficulty in trying to see ourselves through students’ eyes is that students are understandably reluctant to be too honest with us’ (Brookfield, 1995, p. 34).

Maybe this is why Brookfield argues for a third lens, that of the colleague. One of the other teachers, someone who was involved throughout the six-year journey, was asked to provide a potentially critical view of the health initiative undertaken by the school. She was asked because she was well grounded in the common value-system and the pedagogical ideas regarding health in the school. She was asked to write a retrospective, first-person narrative describing key events, involve students in the story and reflect on what might be understood in hindsight.

Finally, the 30 different narratives were re-written into 3 stories in which the different parts created new wholes (see Lieblich, Tuval-Mashiach, & Zilber, 1998). The content of the three stories was then analysed using thematic analysis. Following the work of Lieblich et al. (1998), we used the following question to inform our analysis in step one: What themes regarding health can be identified in the narratives?

**Discourse theory and discourse analysis**

Discourse theory can be described as understanding ways to talk about and be in the world since discourses, in many senses provide different prerequisites for how we can think, talk and act (Phillips & Jorgensen, 2002). Discourse, as a concept, centres on the idea that language follows certain patterns when we move in and between different social domains (Phillips & Jorgensen, 2002). So, to analyse discourses is to identify these patterns. The analysis emanates from the themes identified in the first step and was in step two contextualised in relation to historical patterns regarding health education in school in Sweden (e.g. Quennerstedt et al., 2010).

Discourses are, in this sense, social constructions of health in terms of patterns in language use, patterns located in time as well as in space (Quennerstedt, 2008b). In this way, the discourses involve the ways in which it is possible to talk and act about health in relation to the explored practice. Following Quennerstedt (2008b), discourses were identified as patterns of action through identifying which actions are legitimate or promoted in the narratives. These patterns are related back to the narratives of the teacher,
the colleague and the students as well as to discourses identified in research about PEH in Sweden (e.g. Quennerstedt et al., 2010). However, it is not only the identification of a certain discourse that is of importance. Instead, and as Bolander and Fejes (2009) argue, what lends the analysis weight is showing how the discourses are built up, what the discourses do in practice and also discuss what the consequences of a certain discourse are or might be. The question driving the analysis in this step is: Which health discourses can be identified in the the themes from step one?

In the next two sections, the results of our two analytical steps are presented. In the first section, the context of the school health initiative as well as the health themes identified in the thematic analysis is presented comprehensively in order to get a picture of how we arrived at the identified health discourses. In the second section, the health discourses identified are presented.

**Health and learning in ensemble – a health profile in a school in Sweden**

The aim of the ‘health and learning in ensemble’ project was initially preventative but clearly pathogenic. Health equalled physical health and involved getting all staff (i) physically active at least three times a week, and (ii) more health conscious regarding diet, exercise and sleep. The project was set-up so individual health plans would be established and elementary physical tests conducted on a voluntary basis. Individual health talks, in which discussions revolved around the teachers’ physical health, and from which clear achievable health goals were agreed for later evaluation, were also conducted. Three PE-teacher-led physical activities were scheduled weekly, one of which was planned during working hours. The activities were adapted by the teacher to suit his colleagues’ ambitions and physical status. In contrast to the pathogenic foundations of the initiative, these activities had a clear (but not less important) social purpose. By the end of the year, three health talks had been conducted and almost the whole staff reached the goal of physical activity three times per week.

Psychological and social aspects of health already had a strong presence in the school. This was something that was strengthened even further by an extensive period of developmental work in the whole school concerning policies regarding the value-base in school. The policy of the school stated that:

> Every child has the right to meet high expectations and respect regarding their uniqueness. All children leaving our school should have a positive belief in the future and a strong belief in their own abilities. (translated from the school policy documents)

The value-base of the school was summarised as: ‘the essence of our value-base is to always have the individual student’s best interest at heart and that the students should feel it, know it and expect it’ (translated from the school policy documents).

Taken together, these aspects encouraged the school to broaden the health initiative to include the students as well as relating the initiative to the Swedish national curriculum and the syllabus in PEH where health is described as physical, psychological and social well-being (Quennerstedt et al., 2010). The vision of the school was to allow the school to become a place with a broad health profile based on the national curriculum with a focus on more salutogenic aspects of health. As a result of the project the policy documents of the school were changed to state:
We strive towards being a conscious school where all actors; pupils, staff and parents are included. The health profile consists of several aspects that together aims at developing health. The goal is to give students a greater opportunity to take responsibility for their health, to some extent already now, but in particular later in life. (translated from the school policy documents)

From these basic starting points, the school continuously developed their health profile over the next eight years introducing, for example, health talks with all students, an enhanced sense of ‘we’ and a pride in the school, obstacle courses for motor development, more outdoor activities, focus on what the school called students’ mental barriers, more choice and student influence in PEH, and regular walking during school hours.

This broader understanding of the school’s value-base provides an important context through which to view the five interconnected health themes identified. With regard to health, these themes were identified in the narratives as:

(1) **Values** and the school value-system are about an approach to health that can be described through the use of ‘a tree’ metaphor. Through this metaphor, health is described as strengthening your own and others roots in order to grow and blossom. The metaphor of ‘the team-mate’ is also important in understanding values because all participants are expected to work towards the same goals and build on the same values. These values including basic democratic values of influence, participation and respect for others are the cornerstone in the health project.

(2) **Communication** and discussions are regarded as the main tools for health promotion and health education in order to help all students to develop their health.

(3) Closely connected to communication is **coaching**, in terms of creating the best possible conditions – i.e. a rich soil in the tree metaphor – for all students. It is about creating opportunities and making the school situation comprehensible and manageable for the students.

(4) The theme, **social relations**, is described in the narratives in terms of a sense of community through group activities like hikes and excursions which are organised by the school.

(5) Finally, **personal development** is about developing as an individual, positive thinking and reflection, and is also seen to be about overcoming difficulties and challenges in everyday life.

The stories of the teacher and his colleague reveal similar themes even though the colleague did not teach PEH. What they both highlight as resources for health development are communication, social relations and coaching. These health themes are clearly connected to democratic values and rooted in the common value-system of the school. It is also clear that the narratives convey health from the students’ perspective, i.e. how health resources can be created by the teacher through seeing, listening to and respecting the student. The stories also describe how the teacher and the colleague coach the students into independent thinking, a raised awareness and an ability to take more responsibility themselves. Thus, the students are educated with the school’s value-system as a basis.

The narratives of the students are more focused on what health is. The themes identified are, on the one hand, concerned with social aspects of health, and on the other with
Health-through personal development. This development is achieved by the students gaining confidence to accept the challenges offered. The stories also depict how the group becomes a resource for the individual through pep talks and support. The students’ narratives also show that they view the subject of PEH and the challenges that the investigated practice provides as platforms for personal development.

Health discourses in school practice

In the study, two health discourses were identified from the themes in step one: (1) an individual health discourse rooted in the fostering of personal development, and (2) a value-based health discourse build up around social relations and the fostering of democratic values. In the discourses presented below references are provided to verify the regularities over time in relation to the context the discourses are identified within (Quennerstedt, 2008a).

The individual health discourse

An individual health discourse is clearly visible in the school, and the discourse is rooted in an idea of health and health promotion as conscious citizens taking responsibility for their own health (McCuaig & Hay, 2013; Quennerstedt et al., 2010). It is always the individual student who is at the centre and who is the object for the health effort. Health, thus, becomes a duty to fulfil and it becomes a moral responsibility to be healthy, and the policy documents of the school convey this message:

We strive towards being a conscious school where all actors in the school; pupils, staff and parents are a part. The school profile consists of several parts together aiming at developing health in as many respects as possible. The goal with the health project is to provide pupils with the possibilities to take responsibility for their health to some extent already now but mainly in a life-long perspective. (translated from the school web page, emphasis in original)

In the individual health discourse, students are expected to govern themselves towards a certain given norm regarding health (cf. Öhman, 2010). This is also visible in the student narratives:

One thing I am taking with me from our school is to always think properly in difficult situations (Student’s narrative #6)

What I am bringing with me from school is to think positively and suitably (Student’s narrative #4)

Students describe how they are being ‘coached’ to think in the correct way, indicating that there are wrong ways to think and be. Health as a correct way of thinking related to psychological health is thus normalised, a normalisation similar to that of self-help discourses in society.

The aim of making individuals responsible for health is also present in relation to physical health. The teacher describes:

Per listened, and he embraced it. For the first time he saw the meaning just in trying. For the first time he experienced the beauty in testing his physical capacity and experiencing how fast he really could run. (Teacher narrative #3)
Physical activity here is promoted as something fun and wonderful, something that Per just need to grasp and take responsibility for. It is, and should be, enjoyable to participate in and struggle in movement activities, and if a student resists this norm then exclusion is eminent (McCuaig et al., 2013). This fostering of personal development and achievement underpins individual health discourses visible in the Swedish national curriculum documents for PEH. These documents indicate that students should be provided with the prerequisites to develop their individual abilities regarding physical health in different physical activities (SNAE, 2011).

Similar to notions of PE in general (Garn & Cothran, 2006; Quennerstedt, 2013), health in PEH in Sweden is evidently connected to having fun, sweating and being fit (Öhman, 2010). To fulfill these aims, students in this study should develop their physical capacity, e.g. the aerobic capacity or through resistance training and few opportunities to explore health outside of a pathogenic norm are offered. The health themes of coaching and communication, in this sense, become tools for teaching health and for correct thinking within the individual health discourse and both the narratives of the teacher and the colleague undoubtedly convey this aspect. In the student narratives, this is visible in the idea that they are expected to take on the challenges the school offers.

**The value-based health discourse**

A value-based health discourse is also present in the school’s practice. In contrast to the individual health discourse, the value-based discourse does not prescribe a certain norm for what health is. The prerequisites for how to talk and act in relation to health are less predetermined, and are open for discussion around issues of influence, equality, tolerance and difference (Quennerstedt, 2008a).

The school’s efforts in working with the fundamental values of the school, in general, become, in many senses, equal to working with health. The Swedish national agency for education describe this clearly as:

> Learning, democracy, values and health is closely connected. The mandate for schools to promote children’s and young people’s learning can consequently not be separated from its mandate to educate for democracy. A lot of things rather indicate that these aspects are promoted by the same common factors. Working with the value-base of education in schools as well as the promotion of health should start in a comprehensive view of children’s and young people’s learning and growth and thus also including their everyday school life and the environments they inhabit. (translated from Swedish policy documents about safe school environments, Skolverket, 2007)

The basis for the health profile of the school within this discourse is thus noticeably related to the democracy assignment of schools stated in the Swedish national curriculum where democratic actions and student influence are important ingredients. Themes like coaching, communication and social relations in the narratives become important tools for health promotion but, in this discourse, more in a social and collective sense.

Conversations and communication between teachers and students in the school are of utmost importance for health. The teachers both describe this aspect in terms of:
The teacher sees language and communication as his most important tool [...] But regarding aspects of democracy I also consider the fact that students are respected and that their needs and suggestions are taken seriously. (Teacher narrative #1)

I am on the other hand sure about that Kalle felt that he was being listened to, respected. Not dismissed. (Teacher narrative #9)

Through discussions we create good relations and transfer our values. It must be clear to the students that we have high expectations and that we know that they have the capacity to reach these expectations. (Colleague narrative)

The value-based discourse in the school as a whole makes the idea of health broader and places a clear endeavour of equality and student influence. Social aspects of health, therefore, become the answer to how health practices and democratic values go hand in hand, and the importance of social relations as a health resource is visible not least in the students’ experiences:

[We] talked a lot about how to be and behave in relation to each other, how to do in order to strengthen each others’ roots and not cut them off. You should support and say nice things. (student narrative #20)

[You should] be a good friend and support one another when someone is sad or something. (student narrative #16)

Communication and social relations have a function in the discourse of teaching values through influence and participation in genuine decision-making. In the student narratives, aspects of respect and tolerance towards difference are indicated further.

I didn’t really know that I was bullied in my previous school for 4 years. I thought that was what school was like. [...] I had bad roots and support. Here everybody supported me to strengthen my roots. My classmates supported me and I learned how to participate in the different activities at the school. (student narrative #14)

However, in the narratives, few aspects of what the school is doing within the value-based health discourse can be identified in PEH as a school subject. So even if the PE-teacher was heading the initiative, the value-based discourse mainly can be found in the comprehensive health initiative.

**Health in an Swedish School – a salutogenic perspective**

The basis for the health initiative in the school was to develop a wide notion of health aimed at students’ consciousness and responsibility regarding health. In many senses, this is parallel to what, in the AC:HPE, is described as a strengths-based approach. In this sense, this study supports Lambert’s (2018) results regarding the support needed for a wider notion of health. In the practice of the school, however, both what can be described as salutogenic and pathogenic elements can be found. The individual health discourse dominates the practice of the school, but the discourse can be understood as both being pathogenic and salutogenic. However, pathogenic questions dominate the practice in terms of normalising the students towards a certain individualised version of health. Health understood as a human being’s normal condition is being promoted and variation
from this normality is not something that is explicitly noticed (cf. Quennerstedt, 2008a). Consequently, it is always the students who should be changed.

As the analysis shows, the individual health discourse is particularly evident in PEH. The consequence of this is that certain actions, certain ways of being and, in the end, certain students are excluded because they are not healthy. In excluding these students the ambitions that PEH should be a subject for all are diminished. Health then is mostly about what not to do and the word health becomes imbued with negative connotations. In the school, PEH becomes ‘health-through-sports’, and at least in Sweden, the content of PEH in many senses seems unaffected by wider notions of health in the curriculum (Quennerstedt et al., 2010). The study accordingly reveals that a pathogenic notion dominates what the school and what PEH is doing in the name of health. In this sense, Lambert’s (2018) warning that the support for a strengths-based approach not necessarily equals an understanding of what a strengths-based approach looks like in practice can be confirmed.

In the teacher’s, as well as in the students’, narratives pathogenic notions of health are visible regarding what being healthy is. To think correctly and that ‘just enough’ is always right are clear examples from the student narratives of how a certain norm of health is being taken up, and how students are expected to take responsibility for reaching this norm. At the same time, salutogenic dimensions of health are visible as counter narratives. Indeed, in the value-based health discourse, it is the other way around and salutogenic strengths-based aspects dominate (McCuaig et al., 2013). The value-based health discourse is visible in all three lenses when looking at the practice of health in the school, but most particularly in the student narratives. In the teacher narratives, both pathogenic and salutogenic implications are present, and it seems as if the salutogenic ambition of the school and the teacher is difficult to realise. However, the themes identified related to the value-based health discourse like social relations, communication and democratic values are aspects of health that potentially broadens what is included beyond pathogenic norms. These dimensions can, in a salutogenic perspective, be put forward as important health resources (cf. McCuaig & Quennerstedt, 2018) making health the concern of the whole school.

In the student narratives, social aspects of health dominate over physical aspects, and health rather becomes a collective issue, something we/they do together. It is about supporting others and, in that way, also supporting oneself. So, while the profile of the school seems to be more about an individual health discourse – with many aspects of a pathogenic notion of health – the student narratives rather reflect salutogenic aspects of the discourse in terms of the resources they develop.

In the school’s practice, the two health discourses are weaved together. However, as the practice is dominated by pathogenic stories, the strengths-based approach tends to guide the students towards focusing on deficits, risks and disease. It is accordingly a pathogenic strengths-based approach focusing on prevention rather than a salutogenic strengths-based approach focusing on promotion (McCuaig et al., 2013).

**Concluding remarks**

As several scholars have pointed out, an individual health discourse dominates in society, in school as well as in the school subject of PE (Leahy et al., 2015). However, this has been
challenged by research taking a salutogenic perspective on health and, as a consequence, through the AC:HPE (Macdonald, 2013; McCuaig et al., 2013; Sperka et al., 2018; Varea 2018). An individual health discourse can, to a large extent, be understood as being based in a pathogenic norm, and in the investigated school practice, the individual health discourse did dominate the account of the school health initiative despite the salutogenic intentions of the school and the teachers.

Some of the narratives, however, do provide a more salutogenic notion of health. Not least the students’ stories present a broader view of health. That said, the value-based discourse is present in all three narratives. The study, accordingly, shows the existence of salutogenic dimensions of health in the school, which, in this context, can be viewed as a counter-narrative of the pathogenic hegemony. Conversations and individual health talks with students, social relations, student influence and a focus on democratic values can all be seen as dimensions of health which contribute to a broadening of the concept of health and make it possible to reach new understandings of health in school practice similar to that conveyed in the AC:HPE. Interestingly, when, after the project, the teacher reflected on what he would change in the health initiative, it was the themes deriving from the student narratives relating to social relations, social support, positive experiences and challenges that became the way forward and marked his ambition to move towards a more salutogenic strengths-based education. So by listening to the students the health education in the school became more salutogenic.

Looking closely at the health initiative in the school from a salutogenic perspective, most of the themes regarding health identified in step 1 are important aspects of health in school. In a pathogenic perspective, however, several of these themes would have little to do with health. As McCuaig and Quennerstedt (2018) argue, beyond pathogenic notions of health lies complexity. At the same time, the salutogenic perspective should not be viewed as the opposite of a pathogenic perspective. Issues of risk, diseases or physical health are also of importance in a salutogenic strengths-based perspective but are seen as something promoting or hindering health development, not as the opposite of health. Instead, it is the hegemony of pathogenic notions and the exclusion of other issues of health that is the problem. In PE, health can, taking a salutogenic strengths-based approach, be so much more than only exercise, correct eating habits and correct risk-free behaviour. As we have shown, health, health initiatives, health education or PE in school can potentially be closely connected to value-based education and wider ambitions of education. In this sense, we stress the importance of widening the notion of health building on, and including, areas such as democracy, citizenship, children’s rights, influence, equality, difference or tolerance which makes health the concern for the whole school and not only for PE. Health in PE/PEH/HPE practice can then move beyond notions of activities and questions of what to teach, and also involve issues of how to teach and the educational values of health education. But again, this is only possible and reasonable if we take a salutogenic perspective into consideration.

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References


