Journal of Contemporary Management
Volume 11

Salutogenesis and Sense of Coherence: their promotion in a South African organisation

L LOUW (Rhodes University)
C-H MAYER (Rhodes University)

Abstract

Leaders are in a key position to promote healthy organisations and transform negatively perceived work experiences and interactions, which might lead to ill health, increased medical costs and employee turnover, into positive responses. This paper addresses salutogenesis (health), sense of coherence and leadership from a context-specific positive organisational behaviour perspective by following a mixed-methods case study approach within the pragmatism research paradigm. The unit of analysis was all the top and middle managers (n = 31) at a selected public utility in the Eastern Cape Province.

Data was gathered by the Antonovsky Sense of Coherence questionnaire, in-depth interviews and observation. Research findings indicated that manageability and comprehensibility were more important than meaningfulness; there was significant difference between gender and the average meaningfulness orientation scale; and Indian respondents scoring significantly higher on meaningfulness than African and White respondents. The qualitative data supported the quantitative findings.

Key phrases
health in organisations; positive organisational perspective; salutogenesis; Sense of Coherence (SOC)

1. INTRODUCTION

Leaders in South Africa are confronted with diverse and highly complex challenges, including diversity, becoming a global player, sustainabiltiy and green management, managing communication and organisational issues (Oosthuizen 2012:577). While dealing with these challenges, leaders have to stay healthy, and contribute to the health and well-being of their employees (Mayer 2011:10). Leaders are in a key position to promote a healthy organisational culture, and transform negatively perceived work experiences into positive responses (Mayer & Boness 2013).

In the South African leadership context, health has only recently been researched in depth (Mayer 2011). However, there is still a void in managerial health research regarding the in-

depth understanding of sense of coherence (SOC), health concepts and leadership in terms of positive organisational behaviour.

2. PURPOSE AND CONTRIBUTION

The purpose of this paper is to contribute towards an indepth understanding of salutogenesis (the science of the genesis and development of health) and SOC (Antonovsky 1979) in leaders in a selected organisation from a positive organisational perspective (Mayer 2011:121) by using a mixed methods approach.

To give effect to the research purpose, the objectives of this study, are to:

- determine the SOC profiles of the managers;
- determine whether selected biographical variables such as gender, age and cultural group influence the SOC in managers in the selected organisation; and
- gain a deeper knowledge of salutogenesis (health) of the managers from qualitative perspective.

To achieve the second objective of this study, the following hypothesis has been stated:

- $Ha^{1.1}$: There are statistically significant differences in the average scores of the SOC scales and selected biographical variables, such as gender $H^{1.1a}$, age $H^{1.1b}$ and cultural group $H^{1.1c}$.

The contribution of this paper can be summarised as follows:

- It expands previously published papers on positive organisational behaviour in the specific African context.
- It fills the void of mixed-method (quantitative and qualitative) studies on SOC and health (promotion) and their interrelationships, thereby producing in-depth context-specific findings.
- It contextualises the findings and thereby contributes to building (South African organisational) context-specific positive organisational behaviour approaches.

In the following section, a brief literature review on positive organisational behaviour in the South African management context as well as health, salutogenesis and SOC will be provided.

3. POSITIVE ORGANISATIONAL BEHAVIOUR IN THE SOUTH AFRICAN ORGANISATIONAL CONTEXT

Leadership has been defined as the ability to motivate and influence others to achieve the goals of an organisation (Samani, Koh, Saadatian & Polydorou 2012:160). A leader's ability to

influence others should be based on interpersonal relationships rather than on administration (Amos 2012:374). It is also considered as being an influencing determinant of health and well-being of individuals (Kuopalla, Lamminpaa, Liira & Vainio 2008:904), organisations (Haslam, Reicher & Platow 2011) and of salutogenesis (Krause & Mayer 2012). Leadership affects the health of employees and that of the leaders (Wolf, Huttges, Hoch, & Wegge 2010:220). Employee well-being is positively influenced by leadership behaviour that is empathetic and appreciating (Wegge & Rosenstiehl 2004:475). However, limited research has been published on the relationship between leadership and its impact on health.

Research on leadership in the South African context has hardly been done from a positive organisational behaviour perspective with a focus on health and well-being in organisations (Mayer & Van Zyl 2013). Instead, leadership research has often focused on problematic topics, such as stress and ill health (Jackson & Rothmann 2006) depression, burnout and sickness (Barkhuizen 2003). Research on African management often incorporates an etic (Western) perspective and has been described in a "developing/developed“ world paradigm that is bound to a rather negative view of African leadership (Jackson 2002). Du Plessis and Barkhuizen (2012:20) suggest that in public and private organisations in South Africa, the Human Resources manager is seen as being a change agent and the person responsible for employee well-being. Instead, a general positive paradigm is needed in organisations (Du Plessis & Barkhuizen 2012:17) where leaders and managers actively forge a changed attitude towards a positive perspective to create a strong SOC, health and well-being in organisations (Mayer 2011).

Luthans (2002a:695, 2002b:57) emphasises that more research in the positive organisational behaviour paradigm is needed to integrate the understanding of positive cognitions, affects and bahaviours in organisational settings (Van Zyl & Stader 2013:132). Positive organisational behaviour is defined as “the study and application of positively orientated human resource strength and psychological capacities that can be measured, developed, and effectively managed for performance improvement in today’s workplace” (Luthans 2002b:59).

Previous research has shown that following a positive perspective in organisations strongly affects individual and group-related behaviours in organisations (Lyubomirsky 2013). This paper, therefore, emphasises the positive concept of SOC as well as health and well-being in a selected organisation by asking the question: “What went right?“ instead of “What went wrong?" (Luthans 2002a:698).

4. SALUTOGENESIS AND SENSE OF COHERENCE

In the South African management context, occupational health, health promotion and positive organisational behaviour have become important leadership issues (Van Zyl & Rothmann 2012:369.

However, health and well-being in organisations do not seem to be a major priority in South Africa (Legare & Gelman, 2009:357), although the government views health to be a major priority (South African Department of Labour 2004). Health is described as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity" (World Health Organisation 2002:Internet). Managers still seem to focus on negative concepts, such as absenteism due to sickness, burnout, depression or diseases (Chao, Pauly, Szrek, Pereira, Bundred, Cross & Gow 2007:474). However, it can be said that the positive pyschology concepts have gained interest and salutogenesis and SOC have been tested in various South African settings (Louw, Mayer & Baxter 2012).

Salutogenesis is a construct of the positive organisational behaviour paradigm that refers to individuals as well as to organisations (Riese 2005). Salutogenesis is a concept that describes the development of health and well-being and there is evidence that in South Africa the salutogenic question of "What keeps people healthy?" (Antonovsky 1979) has gained interest in management sciences and industrial psychology (Rothmann & Cilliers 2007:8).

Salutogenesis is based on the major concept of SOC that that includes three components – comprehensibility, manageability and meaningfulness. According to Antonovsky (1987) individuals with a high SOC in comprehensibility perceive challenges as stimulating, and experience them as clear, ordered, structured, consistent and predictable. Individuals with a high SOC in manageability, perceive their work as consisting of experiences that are manageable and with which they can cope by using personal or social resources while a high sense of SOC in meaningfulness implies that individuals can make emotional and motivational sense of work demands and see them as welcome challenges in which they enjoy investing energy.

South African research has found that individuals with a strong SOC experience their work as clear and structured, know how to manage their work effectively, and can cope with it and see meaningfulness in what they do (Mayer 2011:166). Managers with a strong SOC seem to have a more complex idea of what health means to them, how they feel when they feel healthy and what they do to remain healthy (Mayer & Boness 2011).

5. RESEARCH DESIGN

The present study uses a mixed-method single case study research approach (Tashakkori & Teddlie 1998:5) in the pragmatism paradigm. The case study is an empirical enquiry that investigates a contemporary phenomenon in depth in its real-life context (Yin 2009:18).

The pragmatism paradigm has been chosen, because it combines and integrates quantitative and qualitative research approaches (Tashakkori & Teddlie 1998:42) to better understand the phenomenon being researched. From an ontological perspective the external reality is accepted and, even if there might be causal relationships, it is difficult to describe them explicitly (Tashakkori & Teddlie 1998:23). This paradigm embraces a practical and applied research philsophy that considers "the research question to be more important than either the method they use or the worldview that is supposed to underlie the method“ (Tashakkori & Teddlie 1998:21).

5.1 Research approach and strategy

In order to gain an understanding of health and SOC in leaders in an organisattion, an exploratory single-case approach was used. The quantitative approach in this study “consists of establishing causal relationships between the variables by establishing causal laws and linking them to deductive or integrated theory” (Collis & Hussey 2003:53). On the other hand, the interpretative paradigm is based on the epistemological tradition of constructivism (Berger & Luckmann 2000) and interpretative hermeneutics (Habermas 1999), the “thick description” method of Geertz (1987) is used for a qualitative approach in this study.

The public utility used for this case study operates in the Eastern Cape of South Africa. It ranks as one of the top public utilities of its sector in the country. It is a growing organisation with numerous worksites throughout the province.

The selection of this organisation was based on national and regional business involvement and standing:

- diversity of managers and workforce;
- established Affirmative Action and Black Economic Empowerment policies;
- the South African management profile;
- interest of the Human Resource Department, the leaders and managers of the utility in the research topic;
- access to the utility.

During the study, the utility was in the process of restructuring. In this state of change, it was important for it to focus on managerial perspectives regarding health and well-being at work and how they were performed. Therefore, this study has significant value for gaining insight from a mixed methods approach which would have significant implictions after the organisation had undergone the restructuring processes.

5.2 Research method

5.2.1 Population

All the top and middle managers (n = 31) at the selected public utility were invited to participate in this study. However 28 managers completed the questionnaire and 17 managers participated in in-depth interviews to provide qualitative micro-organisational data.

5.2.2 Data collection methods

Quantitative data on SOC was collected by means of a questionnaire using the Antonovsky Life-Orientation Questionnaire (Antonovsky 1997), analysing the dimensions of manageability (10 items), comprehensibility (11 items) and meaningfulness (8 items). The questionnaire consisted of 29, seven point, semantic differential scale questions and were voluntarily completed, and confidentiality was guaranteed. Qualitative data was collected by in-depth interviews that referred to health and well-being, health promotion of employees and observations about the organisation, as well as by analysis of secondary literature and documents.

The managers' in-depth interviews included 20 questions which were explored in depth and which were recorded verbatim to ensure precise transcription. Confidentiality was guaranteed. Time for observations was provided by the Human Resource Department. The observation were used to interprete the findings in the findings section, but are not mentioned explicitly.

5.2.3 Analysis of quantitative research data

Quantitative data was analysed using the R statistical software package (R Development Core Team 2010). Descriptive statistics relating to SOC, such as the mean, standard deviation and frequency distributions, were calculated to summarise the sample data distribution.

As a result of the small size of this data and the exploratory nature of this study, univariate statistical methodologies were used. To determine whether there were significant differences in the average scores for the SOC dimensions (manageability, comprehensibility and

meaningfulness) and and selected biographical variables such as gender, age and cultural group, ANOVAs, suitable t-tests and where appropriate Levene's and Tukeys HSD tests were used. Separate T-tests were conducted on each SOC scale, using pooled estimates for biographical variable variances.

All the scales in the measuring instrument were subjected to Cronbach alpha coefficient analysis for reliability. As a rule of thumb, Cronbach alpha coefficients between 0.60 and 0.70 are regarded as moderate, between 0.70 and 0.80 as good and above 0.80 as being very good to excellent (Hair, Money, Samouel & Page 2007:244). However, because of the small number of respondents in this study, care was taken in the interpretation of the results. Owing to the sample size, the mixed-methods research approach and the fact that this instrument has been well tested in previous studies, it was deemed sufficient to rely on the quantitative validity of the instruments in extensive previous research. Consequently a brief review of previous research pertaining to the reliability and validity of the measuring instrument used in this study will be given.

The SOC scales yield internal reliability indices of between 0.78 and 0.93, as reported in 26 different studies (Antonovsky 1997), as well as test-retest reliability indices of between 0.56 and 0.96. A consistently high correlation coefficient ranging between 0.83 and 0.95 was found by Antonovsky (1993 cited in Cilliers and Kossuth 2004:64). The internal consistency of 0.80 has been confirmed by Jackson and Rothmann (2001), and an internal consistency of 0.91 by Lustig and Strauser (2002:6) and a high test-retest reliability of 0.91 after six weeks by Radmacher and Sheridan (1989 cited in Cilliers and Kossuth 2004:64. The SOC instrument seems to be cross-culturally applicable since it has been used in at least 33 languages in 32 countries both Western countries and countries such as Thailand, China, Japan, and South Africa. The SOC scale has been validated for the South African context (Randall 2007:4). South African studies on salutogenesis and SOC (Mayer 2011; Strümpfer & Wissing 1998) have focused on SOC in work contexts (Mayer & Boness 2009; Mayer, Louw & Louw 2010).

Regarding the qualitative data, qualitative research criteria were considered, such as confirmability (Riege 2003:78; Seale 2002:105), credibility (Poggenpoel 1998:349), transferability (Van der Riet & Durrheim 2008:80) and dependability (Collis & Hussey 2014:172). Relevant strategies of qualitative data collection, analysis and interpretation were used.

5.2.4 Analysis of qualitative research data

Qualitative data on health and well-being was analysed by content analysis and according to the five-step process of Terre Blanche, Durrheim and Kelly (2006:322-326). Data analysis was conducted to analyse and interpret data as follows: Step 1: familiarisation and immersion (reading the data in-depth, making notes, brainstorming); Step 2:inducing themes (labelling overall themes using the interviewees' language, defining overall concepts and key terms that lead to categorisation and coding); Step 3: coding (coding of data under the overall themes); Step 4: elaboration (new construction of data that is rearranged in a new order providing new perspectives); and Step 5: interpretation and checking of data (interpretation of qualitative data). After the quantitative and the qualitative data were analysed and interpreted, they were integrated and again interpreted.

5.3 Ethics

Ethical considerations were approved by the utility and the research institution, which included the respect accorded to the rights of the participants, informed consent, confidentiality and anonymity, and transparency (Mayer 2008:108).

5.4 Limitation of this research

The limitation of this research is that it was based on one selected organisation with a limited number of respondents representing management. This research should be viewed as exploratory in nature. Despite this, other similar parastatals could benefit by drawing on these research findings.

In the following section the findings are reported in quantitative and qualitative reporting styles, according to the research methods used.

6. RESEARCH FINDINGS

6.1 Biographical data

With regard to the biographical information, the most prevalent age group was between the ages of 40-49 (36.67%) and the majority of the respondents were male (76.67%). Middle management comprised 86.20% of the sample and top management 13.80%. Seventy-six percent of the respondents were religious, and 70% were married. Forty-five per cent of the respondents were from the African group, 38% from the White group, 14% from Indian and 3% from the Coloured group.

6.2 Quantitative findings on Sense of Coherence

In this research the Cronbach alpha coefficients for the SOC scales, according to the Antonovsky Life Orientation Questionnaire, were moderate for comprehensibility (0.683), good for manageability (0.734) and very good for meaningfulness (0.811).

In response to the first research objective on the SOC profiles of the managers, data was cleaned by deleting subjects who left seven (approximately 25%) or more items blank or who left 30% of the items for a scale blank. This resulted in 28 usable responses. As can be seen in Table 1, manageability and comprehensibility were more important to managers than meaningfulness.

TABLE 1 : SOC profile for Antonovsky questionnaire

SOC scales	Valid N	Mean	Standard Deviation
Manageability	28	53.3214	6.5039
Comprehensibility	28	52.8214	7.0082
Meaningfulness	28	46.0357	5.8594

Source: Authors

In response to the second research objective pertaining to the influence of selected biographical variables on the SOC in managers, the data on male and female populations, based on separate Levene's tests, provided sufficient evidence that there were significant differences in the population variances. Consequently, separate t-tests were conducted on each SOC scale, using separate estimates for the population variances.

As shown in Table 2, it was found that there was a significant difference between the average meaningfulness orientation scale and gender, at the 5% level of significance: meaningfulness (t = 2.2344, df = 13,713, p-value = 0.0426). There were no significant differences between the average comprehensibility and manageability orientation scales and gender at the 5% level of significance. The alternate $H^{1.1a}$ is thus not supported except in terms of gender and meaningfulness.

There were no significant differences between the average scores on any of the SOC scales and the various age groups at the 5% level of significance, based on a one-way ANOVA analysis, as shown in Table 3. $Ha^{1.1b}$ is thus not supported.

TABLE 2: Difference between SOC orientation and gender

SOC orientation	Mean	Mean	t-value	df	p	Valid N	Valid N	SD	SD
	Female	Male				Female	Male	Female	Male
Comprehensibility	50.857	53.476	-0.899	11.359	0.387	7	21	6.4917	7.202
Manageability	55.286	52.667	1.036	12.960	0.319	7	21	5.4072	6.822
Meaningfulness*	49.571	44.857	2.234	13.713	0.043	7	21	4.4293	5.885

* $p < 0.05$

Source: Authors

TABLE 3: Difference between SOC orientation and age

SOC orientation	SS	df	MS	SS	df	MS	F	p
	Effect	Effect	Effect	Error	Error	Error		
Comprehensibility	142.63	4	35.656	1183.48	23	51.456	0.693	0.604
Manageability	242.77	4	60.693	899.34	22	39.102	1.552	0.221
Meaningfulness	130.32	4	32.580	796.65	24	34.637	0.941	0.458

Source: Authors

As shown in Table 4, there were no significant differences in the average scores on the comprehensibility and manageability scales between the various cultural groups at the 5% level of significance. However, significant differences in the average meaningfulness scores existed between the various cultural groups ($F = 3.7037$, df = 3, 23, p-value = 0.02612).

TABLE 4: Difference between SOC orientation and cultural groups

SOC orientation	SS	df	MS	SS	df	MS	F	p
	Effect	Effect	Effect	Error	Error	Error		
Comprehensibility	266.46	3	88.821	1056.20	23	45.922	1.934	0.152
Manageability	87.55	3	29.184	897.11	23	39.005	0.748	0.535
Meaningfulness*	301.58	3	100.526	624.27	23	27.142	3.704	0.026

* $p < 0.05$

Source: Authors

More specifically, there were significant differences between the average African and Indian meaningfulness scales scores (p-value = 0.0263) and the average White and Indian meaningfulness scale scores (p-value = 0.0416), based on Tukey's HSD test. At the 5% level of significance the Indian respondents had significantly higher average scores than the African and White respondents. Hypothesis $Ha^{1.1c}$ is thus not supported, except for the difference in average score of meaningfulness and cultural groups.

6.3 Qualitative findings on salutogenesis (health) and health promotion

In the following section, excerpts of the qualitative findings will be presented by including quotes and interpretations. The findings are structured according to the themes (health and health-promotion in terms of salutogenetic health development), sub-themes (health feeling, sick leave, meaning of health, promoting health, organisational and personal impact on health) and key words (presented below the research questions), as analysed through content analysis.

6.3.1 Health: how healthy do you feel?

During the interviews, managers were asked how they felt in terms of their general health on the day of the interview. On a scale from 0 (feel very sick) to 10 (feel very healthy) (0-3 low health, 4-6 medium health, 7-10 good health) managers responded as follows: one manager scored 5 (P4); two managers scored 6 (P7, P15); five managers scored 7 (P1, P5, P6, P12, P13); three managers scored 7-8 (P9, P14, P17);three managers scored 8 (P2, P3, P16); two managers scored 9 (P10, P11); and one manager scored 10 (P8).

This self-evaluation by the managers regarding their subjective health shows that fourteen managers scored higher than 7 (good health) on the scale, and only three scored below 7 (medium health). This shows that the subjective health perception seemed quite positive, without any of the managers scoring below 5. This finding shows a positive perception with regard to the managers' subjective health and well-being, and points to a positive attitude towards subjective health and well-being.

6.3.2 Health: sick leave during the past year?

According to their statements, the seventeen managers interviewed had taken 56 days of sickness altogether during the past 12 months. The average amount of sick leave per manager interviewed was 5 days per year. Four of the managers did not take any sick leave during the described time.

The managers were highly aware of their health, and described their perceptions of sick leave. Seven managers (P1, P3, P7, P10, P11, P13, P14) stated that they usually went to work when they were sick with flu or a minor sickness. Seven (P2, P4, P5, P6, P8, P12, P17) said that they preferred to stay at home and get healthy before they returned to work.

6.3.3 Health: what does it mean for you?

The managers who were interviewed defined health in various ways, such as: overall well-being (P3, P4, P11, P12); being active (P4, P9, P14, P16); enjoying healthy nutrition (P9, P13, P14); being productive (P6, P15, P17); being free of sickness and pain (P7, P10); having a balanced life (P7, P8); spending time with God (P8, P17); being in good physical condition (P5); happiness (P17); and high life quality (P1).

Most of the health concepts were defined in a positive organisational behaviour paradigm. Only two managers defined health negatively, namely in terms of the absence of pain and sickness. To four managers, health was: overall well-being (P3, P4, P11, P12). P3, a white female manager, defined health as follows:

„It's well-being, your overall wellbeing. And it's my mental state as well as my physical state. For me, that's what it – it's my overall holistic well-being, that's what I consider as health". (P3).

P3, this female manager explained that to her health was her physical and psychological well-being that affected her in a holistic and mutual way. Four male managers felt healthy when they were "active" (P4, P9, P14, P16) in terms of exercising, walking, working at home, gardening (P14), going to the gym, weight- lifting (P9), cycling and enjoying healthy nutrition (P9, P13, P14). P14 saw health in a functional term as an investment into oneself and the organisation: "Your health is your investment, that's why you have to look after yourself, it's an investment into yourself and the organisation." Health to these managers meant that they valued life and had a high life quality (P1) were happy (P17) and being productive (P6, P15, P17) as well as being "free of sickness / pain" (P7, P10) being in a "good physical condition" (P5) and enjoying a balanced life (P7, P8) and time with God (P8, P17)

These results show that managers in this organisation had broad and various ways of defining health, including physical, emotional, mental, psychological and spiritual aspects of life. Health to them was more than "being free of pain and sickness". These respondents were highly aware of the fact that health is connected to "overall well-being". It is interlinked with the identity of the person and a balanced life with high life quality. The managers defined health by referring to physical, emotional, mental, psychological and spiritual

elements. Most of the managers defined health in a positive way and thereby constructed an attitude of positive organisational behaviour, which would also be reflected in the organisational culture and the employees.

6.3.4 Health: what do you feel when you feel healthy?

The respondents said that when they were healthy they felt: energetic (P4, P7, P10, P11); good (P1, P13. P15); at peace (P9, P12); positive (P2, P8); in control (P4); not sick (P3, P9); relaxed (P1); light (P3); and spiritually sound (P12). With the exception of one statement, all the statements were in a positive organisational paradigm, highlighting positive feelings such as energetic, good, peaceful, positive, in control, relaxed, light or spiritual sound. Only one manager (P9) replied that when he felt healthy he did not feel sick.

P12 manager emphasised the importance of spirituality, and stated that his connection to God impacted on his health:

"When I feel healthy, it's when I feel spiritually sound, which means that I feel that I am connected to my God. Connected in the sense that there are no issues around condemnation and, you know, those other issues. And I usually feel, I feel content. I feel peace and content with myself."

Feeling healthy meant to this male black manager that he was connected to God, that he could live his spirituality, when he felt interlinked and when he was connected in terms of positive issues in his life. Being healthy was also connected to a deep contentment, inner peace and contentment with himself. The connection to God as an outer force and power reflected at the same time the inner connection to himself, to his soul.

The findings show that feeling healthy was based on positive concepts of being energetic, peaceful, positive, relaxed, light, spiritually sound, in control and good. Only two of the interviewees defined health in terms of negative descriptions regarding ill health. This shows that with regard to the health feeling, most of the participants had a positive behavioural approach.

6.3.5 Health promotion: how do managers promote health?

The respondents maintained personal strategies to remain healthy and promote health and well-being at work while being exposed to a challenging work environment. The following health-promoting strategies were mentioned: twelve managers did sport (P1, P5, P6, P7, P8, P9, P10, P11, P12, P15, P16, P17); ten kept healthy nutrition (P1, P4, P6, P10, P11, P13, P14, P15, P16, P17); four mentioned their family (P1, P5, P8, P17); four highlighted positive

people (P4, P9, P16, P17); three emphasised looking after yourself (P2, P5, P11); two mentioned managing stress (P10, P14); two mentioned meditation and reflection (P3, P7); two highlighted a spiritual life (P8, P9); and one mentioned reading (P4). Twelve of the seventeen managers (P1, P5, P6, P7, P8, P9, P10, P11, P12, P15, P16, P17) did sport to keep healthy; and ten referred to healthy nutrition when talking about health- promoting strategies (P1, P4, P6, P10, P11, P13, P14, P15, P16, P17). The family was also very important in keeping healthy (P1, P5, P8, P17).

A good home environment, being married, and having children contributed to good health of managers in the organisation. It helped not only from a physical, but also from a psychological viewpoint (P1). Therefore, a happy family life contributed to healthy leadership and a healthy organisational culture. Other managers thought that keeping healthy was connected with meeting “positive people” (P4, P9, P16, P17) and “looking after yourself” (P2, P5, P11). Two managers believed in “meditation and reflection” (P3, P7) as activities to keep healthy. Two others pointed out that being able to live a “spiritual life” (P8, P9) and having time to read (P4) were very important aspects for them to keep mentally healthy.

The findings show that the majority of these managers used strategies to remain healthy primarily in terms of physical health, such as sports and diet. However, there were also psychological factors influencing health, such as personal family life, the interrelationships with positive people, and the ability to manage stress mentally. Some managers referred to spiritual development in terms of meditation, reflection and reading to develop their health in terms of salutogenesis. Findings show that healthy leadership is not connected only to physical health, but also to psychological, mental and spiritual attitudes and practices to remain healthy and contribute to a healthy organisation, promoting comprehensibility, manageability and meaningfulness.

6.3.6 Health promotion: the organisation’s impact on improving managerial health

Respondents saw a huge influence in organisational management and leadership with regard to improving healthy organisational behaviour and healthy employees. The following aspects were pointed out to improve organisational behaviour: managing the organisation (P3, P5, P6, P7, P8, P10, P12, P13, P14, P15); improving facilities in the organisation (P1, P2, P4); remuneration (P15); and "no improvement needed" (P9, P16).

Ten managers said that how the organisation was managed and led, strongly influenced managerial health in the organisation. (P3, P5, P6, P7, P8, P10, P12, P13, P14, P15), giving

the main responsibility for managerial health to the management. A healthy management included fairness and equality (P5), as well as empathy (P3, P8). Three managers (P1, P2, P4) stressed the importance of "facilities in the organisation" to improve managerial health, which included, for example, providing a refrigerator to stock healthy food in the leaders' offices (P1); providing a fitness room at work (P2); and providing a "sick room" where a person could lie down if not feeling well. One manager suggested that "an improved remuneration" (P15) would improve his health, and two managers thought that "no improvement is needed" (P9, P16).

6.3.7 Health promotion: personal impact on improving managerial health

Managers viewed the personal impact on their health as being very important and being influenced by: physical exercise (P1, P2, P3, P4, P5, P15); healthy nutrition (P3, P4, P7, P9, P11, P13); way of managing work (P12, P16, P17); and lifestyle (P4, P8, P13); but there were also two "no improvement needed" (P9, P10).

Six managers believed that they could improve their health through "physical exercise" (P1, P2, P3, P4, P5, P15)' healthy nutrition (P3, P4, P7, P9, P11, P13); and a well-organised and managed work and life plan ("managing work") (P12, P16, P17). To three managers "Life style / meaning in life" (P4, P8, P13) was highly important. Two managers indicated "no improvement needed" (P9, P10). Only a few thought that they could still improve their health, and they did not see the necessity of doing so. However, health could be improved individually through "physical exercise", "healthy nutrition" and the way managers "manage work". Generally, managers could improve individual health through "life style or meaning in life". This shows that managers' concepts of health are mainly bound to physical health that can be improved through exercise and nutrition in the first instance. This might be due to the fact that mental, emotional, psychological and spiritual health concepts did not seem to be as deeply rooted in managerial health concepts as physical health concepts.

7. DISCUSSION

A developed SOC tends to have an impact on individuals (Strümpfer 1990:45), such as experiencing the workplace as stimulating, clear, ordered, structured, consistent and predictable, and as a challenge they can cope with. A strong SOC is directly related to keeping healthy despite stress, and to maintaining personal balance (Geyer 1997:1771). Qualitative findings showed that managers in this organisation viewed themselves as very healthy and in a good and healthy condition, thus referring to salutogenesis and indicating that they have a strong sense of SOC in terms of all the three components.

With reference to the quantitative findings in this study, it was found that manangeability and comprehensibility were more important than meaningfulness. Most important was manageability, implying that the managers were confident that difficulties could be solved by using personal or social resources. Manageability is developed through the experience of one's own resources and the belief that tensions can be kept in balance and managed.

Qualitative findings strongly supported this finding, because managers particularly emphasised aspects of manageability with regard to their health, such as being energetic and active, as well as productive and in control, and eating healthily. This shows that they viewed activism and manageability in terms of health, physical and psychological functioning, as being most important.

Findings on the health-promoting strategies and salutogenesis support this finding; the managers felt that they were able to manage their health and contribute actively to their well-being, thereby developing their health salutogenically. They used various coping strategies (doing sports, healthy diet, being with family etc.) and applied them in their daily life and work routine. They also believed that the organisational management could contribute to their health, but in comparison with the individual statements on what they as individuals could do for their health, the individual manageability, as a component of sense of coherence, was more important than the organisational influence.

Comprehensiblity was regarded as being of second importance, indicating that the managers' sense of comprehensibility was relatively well developed. The respondents deemed it important to be able to process familiar and unfamiliar stimuli as ordered, consistent, structured information, and not chaotic, random, accidental and inexplicable. The interviews showed that the managers understood the complexities of their work and the interrelationships with regard to their personal health and well-being. They felt healthy when their lives were "balanced".

The sense of meaningfulness, as a major component of sense of coherence, was least important to the managers. Meaningfulness is fostered by the feeling of having influence on the shaping of situations. It is considered to be the most important component, because without meaningfulness, life is experienced as a burden (Antonovsky 1987; Bengel, Strittmatter & Willmann 2001). These managers at the public utility thought it was less important to make emotional and motivational sense of work demands and, by implication, preferred not to invest their energy in these types of challenges. The qualitative findings

support the quantitative findings. Only selected managers highlighted meaningfulness and sources of motivation during the interviews.

7.1 Biographical variables and sense of coherence

Indian respondents had significantly higher average meaningfulness scores than the African and White respondents, indicating that the Indian respondents felt that they had more influence over the shaping of situations and the ability to make emotional and motivational sense of work demands. Therefore they had a more positive orientation towards meaningfulness, as supported by previous research (Mayer 2011). This finding was also suppoted in the qualitative findings, in which Indian respondents particularly highlighted the importance of God and religion as the key to a healthy work life.

8. CONCLUSION, IMPLICATIONS AND RECOMMENDATIONS

This paper aimed at providing an in-depth understanding of SOC, salutogenesis and health promotion regarding leadership in the positive organisational leadership paradigm.

Sense of coherence, being a positive organisational behaviour concept, was well established in the organisation in terms of the following aspects: managers at the public utility deemed their abilities to solve difficulties by using personal or social resources (manageability), and process familiar and unfamiliar stimuli as ordered, consistent and structured information (comprehensibility), as being the most important. Of less importance was the abilty to make emotional and motivational sense of work demands (meaningfulness) and, by implication, they preferred not to invest their energy in emotional or motivational work-related challenges.

Qualitative findings support the quantitative finding that manageability of work and health was most important for the respondents, followed by comprehensibility and meaningfulness. Interview findings showed that particularly Indian and female managers referred to the meaningfulness of their work in the frame of their personal life, with special regard to the social impact of their work (female managers) and their connection to God or a higher power (Indian managers).

Qualitative findings show that these leaders had a very positive approach to health and well-being and mainly thought and worked in the positive organisational paradigm, followed a health-orientated leadership approach and defined health and well-being as concepts of positive organisational behaviour.

In addition, the findings emphasise that the interviewees connected their individual and subjective concepts of health and well-being with their aim to construct a healthy organisational culture across hierarchy levels. They developed their personal strategies to promote health within the organisation, particularly while managing challenging work situations effectively, supporting the finding of a high sense of manageability amongst the managers. In this regard, they also explained how they promoted a healthy leadership within the organisation and thereby contributed to general positive organisational behaviour and a culture of health. They seemed to view their individual manageability and responsibility for their health as more important than organisational influences.

The theoretical implications of this research show that further research is needed on SOC in various organisational settings, particularly studying cultural and gender aspects in South African settings.

Although there was generally a high level of SOC among the leaders of the public utility, and health was considered as being prevalent, it is recommended that: the SOC of individuals, and of the organisation in general, be strengthened to promote a culture of positive organisational behaviour and meaningfulness. The organisation should also consider how to improve the sense of meaningfulness, such as having leadership development programmes focusing on emotional intelligence and motivation, so as to make bettter sense of work demands. In these programmes emphasis should be placed on understanding the concept of meaningfulness by emphasising the importance of being able to relate situations and experiences at work to the meaning of personal life and purpose in life. Despite the current well developed sense of comprehensibility amongst the managers in the organisation, given the changing environment and the context of change in the organisation, managers will not always experience challenges in a structured environment. It is thus recommended that a leadership development programme also address how the mangers process information in unfamiliar environments.

REFERENCES

AMOS TL. 2012. The dynamics of leadership. In HELLRIEGEL D, SLOCUM J, JACKSON SE, LOUW L, STAUDE G, AMOS TL, KLOPPER HB, LOUW MJ, OOSTHUIZEN TFJ, PERKS S & ZINDIYE S. 2012. Management. 4th South African edition. Cape Town: Oxford University Press Southern Africa. pp. 370-401.

ANTONOVSKY A. 1979. Health, stress and coping. San Francisco, CA: Jossey-Bass.

ANTONOVSKY A. 1987. Unravelling the mystery of health: how people mange stress and stay well. San Francisco, CA: Jossey-Bass.

ANTONOVSKY A. 1993. Complexity, conflict, chaos, coherence, coercion and civility. In CILLIERS F & KOSSUTH SP. 2004. The reliability and factor structure of three measures of salutogenic functioning. *South African Journal of Labour Relations* 28(2):59-76.

ANTONOVSKY A. 1997. Salutogenese – Zur Entmystifizierung der Gesundheit. Tübingen: Dgtv-Verlag.

BARKHUIZEN N. 2003. Occupational stress, burnout and work engagement of academic staff of universities in the North West Province. Potchefstroom: North West University. (Masters thesis.)

BENGEL J, STRITTMATTER R & WILLMANN H. 2001. Was erhält Menschen gesund? Antonovskys modell der salutogenese – diskussionsstand und stellenwert. (Forschung und Praxis der Gesundheitsförderung, Band 6). Köln: Bundeszentral für gesundheitliche Aufklärung.

BERGER PL & LUCKMANN T. 2000. Die gesellschaftliche Konstruktion der Wirklichkeit. Eine Theorie der Wissenssoziologie. 17th ed. Frankfurt, Germany: Fischer.

CHAO L-W, PAULY M, SZREK H, PEREIRA NS, BUNDRED F, CROSS C & GOW J. 2007. Poor health kills small business. Illness and microenterprises in South Africa. *Health Affairs* 26(2):474-482.

COLLIS J & HUSSEY R. 2003. Business research: a practical guide for undergraduate and postgraduate students. 2nd ed. New York, NY: Palgrave Macmillian.

COLLIS J & HUSSEY R. 2014. Business research: a practical guide for undergraduate and postgraduate students. 4th ed. New York, NY: Palgrave Macmillan.

DU PLESSIS Y & BARKHIUZEN N. 2012. Psychological captial, a requisite for organisational performance in South Africa. *South African Journal of Economic and Management Sciences* 15(1):6-30.

GEERTZ C. 1987. Dichte beschreibung. Beiträge zum verstehen kultureller systeme. Frankfurt, Germany: Suhrkamp.

GEYER S. 1997. Some conceptual considerations on the sense of coherence. *Social Science Medicine* 44(12):1771-1779.

HABERMAS J. 1999. Theorie des kommunikativen handelns. 3rd ed. Frankfurt, Germany: Suhrkamp.

HAIR JF, MONEY AH, SAMOUEL P & PAGE M. 2007. Research methods for business. West Sussex, UK: Wiley.

HASLAM SA, REICHER SD & PLATOW MJ. 2011. The new psychology of leadership: identity, influence and power. New York, NY: Psychology Press.

JACKSON T. 2002. The management of people across cultures: valuing people differently. *Human Resource Management* 41(4) 455-475.

JACKSON L & ROTHMANN S. 2001. Sense of coherence, self efficacy, and locus of control as predictors of job satisfaction. Praque, Czech Republic: European Congress on Work and Organisational Psychology. (10th European Congress on Work and Organisational Psychology; 16-19 May.)

JACKSON L & ROTHMANN S. 2006. Occupational stress, organisational commitment, and ill-health of educators in the North West Province. *South African Journal of Education* 26(1):75-95.

KUOPALLA J, LAMMINPAA A, LIIRA J & VAINIO H. 2008. Leadership. Job well-being and health effects – a systematic review and a meta-anaysis. *Journal of Occupational and Environmental Medicine* 50(8):904-91 .

KRAUSE C & MAYER C-H. 2012. Gesundheitsressourcen erkennen und fördern. Training für pädagogisches fachpersonal. Göttingen, Germany: Vandenhoeck and Ruprecht.

LEGARE CH & GELMAN SA. 2009. South African children's understanding of AIDA and flu: investigating conceptual understanding of cause treatment and prevention. *Journal of Cognition and Culture* 9:357-370.

LINDSTRÖM B & ERIKSSON M. 2005. Salutogenesis. *Journal of Epidemiology and Community Health* 59(6):440-442.

LOUW L, MAYER, C-H & BAXTER J. 2012. Exploring relationship between value- and life-orientation and job satisfaction. *Acta Commercii* 12:45-67.

LUSTIG DC & STRAUSER DR. 2002. The relationship between sense of coherence and career thoughts. *Career Development Quarterly* 51:2-11.

LUTHANS F. 2002a. The need for and meaning of positive organisation behavior. *Journal of Organisational Behavior* 23:695–706.

LUTHANS F. 2002b. Positive organisational behavior: developing and managing psychological strengths. *Academy of Management Executive* 16:57–72.

LYUBOMIRSKY S. 2013. The myth of happiness: What should make you happy but doesn't, what shouldn't make you happy but does, what happiness really is – and isn't. New York, NY: Penguin.

MAYER C-H. 2008. Manging conflict across cultures, values and identities. Marburg, Germany: Tectum.

MAYER C-H. 2011. The meaning of sense of coherence in transcultural management. Münster, Germany: Waxmann Publications.

MAYER C-H & BONESS CM. 2009. Conflict, identity and sense of coherence in managers. A case study from South Africa. *Journal of Contemporary Management* 6:39-63.

MAYER C-H & BONESS C. 2011. Concepts of health and well-being in managers: an organisational study. *International Journal of Qualitative Studies on Health and Well-being* 6(4):7143 [Internet: http://www.ijqhw.net/index.php/qhw/article/view/7143, DOI: 10.3402/qhw.v6i4.7143; downloaded on 2013-09-20.]

MAYER C-H & BONESS CM. 2013. Creating mental health across cultures. Coaching and training for managers. Lengerich, Germany: Pabst Publishers.

MAYER C-H & VAN ZYL LE. 2013. Perspectives of female leaders on sense of coherence and mental health in an engineering environment. *SA Journal of Industrial Psychology* 39(2). [Internet: http://dx.doi.org/10.4102/sajip.v39i2.1097; downloaded on 2013-09-20]

MAYER C-H, LOUW L & LOUW MJ. 2010. Sense of coherence and organisational commitment: a case study in a selected South African parastatal. Mpekweni Beach Resort near Port Alfred: SAIMS. (22nd Annual Conference of the Southern Africa Institute for Management Scientists; 12-15 Sep.) (Competitive paper.)

OOSTHUIZEN TFJ. 2012. Contemporary issues in management. In HELLRIEGEL D, SLOCUM J, JACKSON SE, LOUW L, STAUDE G, AMOS TL, KLOPPER HB, LOUW MJ, OOSTHUIZEN TFJ, PERKS S & ZINDIYE S 2012. Management fourth South African edition. Cape Town: Oxford University Press Southern Africa. pp. 574-608.

POGGENPOEL M. 1998. Data analysis in qualitative research. In DE VOS AS (ed). Research on grass roots: a primer for the caring professions. Pretoria: Van Schaik. pp. 334-353.

RADMACHER SA & SHERIDAN CL. 1989. The global inventory of stress: a comprehensive approach to stress assessment. In CILLIERS F & KOSSUTH S.P. 2004. The reliability and factor structure of three measures of salutogenic functioning. *South African Journal of Labour Relations* 28(2):59-76.

RANDALL SJ. 2007. A validation study of the sense of coherence scale using two South African samples. Johannesburg: University of Witwatersrand. (MA Thesis.) [Internet: http://wiredspace.wits.ac.za/handle/10539/2171; downloaded on 2014-02-18.]

R DEVELOPMENT CORE TEAM. 2010. R: A language and environment for statistical computing. R Foundation for Statistical Computing. Vienna, Austria. [Internet: http://www.R-project.org/; downloaded on 2013-08-12.]

RIEGE AM. 2003. Validity and reliability tests in case study research: a literature review with 'hands-on' applications for each research phase. *Qualitative Market Research: An International Journal* 6(2): 75-86.

RIESE J. 2005. Salutogenesis in social systems: self, identity, and robustness of the organisation. Munich: EURAM. (*European Academy of Management Conference; 4-7 May.) (Work-in-progress paper.)* [Internet: http://www.sfb637.uni-bremen.de/pubdb/repository/SFB637-A2-05-001-IC.pdf; downloaded on 2013-05-01.]

ROBINSON JP, SHAVER PR & WRIGHTSMAN LS. 1991. Criteria for scale selection and evaluation. In ROBINSON JP, SHAVER PR & WRIGHTSMAN LS (eds). Measures of personality and social psychological attitudes. San Diego, CA: Academic Press. pp. 1-16.

ROTHMANN S & CILLIERS FVN. 2007. Present challenges and some critical issues for research in industrial/organisational psychology in South Africa. *South African Journal of Industrial Psychology* 33(1):8-17.

SAMANI HA, KOH, JTKV, SAADATIAN E & POLYDOROU D. 2012. Towards robotics leadership: an analysis of leadership characteristics and the roles robots will inherit in future human society. In PAN JS, CHEN SM & NGUYEN NT (eds). ACIIDS. Part II, LNAI 7197. pp. 158-165.

SEALE C. 2002. Quality issues in qualitative inquire. *Qualitative Social Work* 1(1): 97-110.

SOUTH AFRICAN DEPARTMENT OF LABOUR. 2004. Occupational Health and Safety Act as amended by Occupational Health and Safety Amendment Act, No 181 of 1993. [Internet: www.labour.gov.za; downloaded on 2010-01-17.]

STRüMPFER DJW. 1990. Salutogenesis: a new paradigm. *South African Journal of Psychology* 20 (4):45-52.

STRüMPFER DJW & WISSING MP. 1998. Review of South African data on the sense of coherence scales as a measure of fortigenesis and salutogenesis. Durban: PsySSA National Congress. (PsySSA National Congress; 12-13 June.)

TASHAKKORI A & TEDDLIE C. 1998. Mixed methodology: combining qualittive and quantitative approaches. Applied Social Research Methods Series, Voume 46. Thousand Oaks, London: Sage.

TERRE BLANCHE M, DURRHEIM K & KELLY K. 2006. First steps in qualitative data analysis. In TERRE BLANCHE M, DURRHEIM K & PAINTER D (eds). Research in practice: applied methods for the social sciences. Cape Town: University of Cape Town. pp. 321-344.

VAN DER RIET M & DURRHEIM K. 2008. Putting design into practice: writing and evaluating research proposals. In TERRE BLANCHE M, DURRHEIM K & PAINTER D (eds). Research in practice: applied methods for the social sciences . Cape Town: University of Cape Town. pp. 80–112.

VAN ZYL LE & STADER MW. 2013. The strengths based coaching. In WHITE J, MOTCHING R & LUX M (eds). Theory and practice of the person-centered approach: interconnections beyond psychotherapy New York, NY: Springer. pp. 132-149.

VAN ZYL LE & ROTHMANN S. 2012. Beyond smiling: The development and evaluation of a positive psychological intervention aimed at student happiness. *Journal of Psychology in Africa* 22(3):369-384.

WEGGE J & ROSENSTIEL L.V. 2004. Führung. In SCHULER H (ersg). Lehrbuch Organisationspsychologie Bern: Huber. S. 475-512.

WOLF S, HUTTGES A, HOCH, JE & WEGGE, J. 2010. Führung und Gesundheit. In: WINDEMUTH D, JUNG D & PETERMANN O (Hg). Praxishandbuch psychische Belastungen im Beruf. Vorbeugen – erkennen – handeln. Stuttgart . S. 220-231.

WORLD HEALTH ORGANISATION. 2002. Constitution of the World Health Organisation. [Internet: http://whqlibdoc.who.int/hist/official_records/constitution.pdf; downloaded on 2009-06-26.]

YIN RK. 2009. Case study research: design and methods. 4th ed. London, UK: Sage.