# Development of an Interrelated Definition of Psychosocial Health for the Health Sciences Using Concept Analysis

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## ABSTRACT

The term *psychosocial health* encompasses a variety of definitions and references among different disciplines, and it is widely used in various settings within the health professions and health sciences; however, the term is difficult to conceptualize, which has led to its random and unspecified usage. To bring clarity to use of this term, a concept analysis was conducted. After a careful selection process, 15 articles, including those with their primary published definition, were analyzed and synthesized. The central attributes of the concept of psychosocial health were identified, and an overarching definition addressing its various aspects was proposed. The resulting definition is comprehensive and applicable to a variety of disciplines within the health professions. The definition provides a new understanding and increased clarity for this complex term. Importantly, it will also assist in promoting the psychosocial health of patients as well as health professionals. [*Journal of Psychosocial Nursing and Mental Health Services, xx*(xx), xx-xx.]


Although the term *psychosocial health* has become increasingly popular over the past few decades, it covers a wide range of definitions and references among different disciplines, including in relation to health and illness (Taylor & McAvoy, 2015). The term is widely used within the health professions and health sciences. In addition, the promotion of psychosocial health has become more important in the daily work of health professionals in various settings, as well as in health promotion practice (Glanz et al., 2008).

The underlying assumptions as to what constitutes psychosocial health are the basis for multiple concepts in practice, such as the commonly used Activities of Daily Living (ADL) Index, developed by

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**TABLE 1**

**STEPS OF CONCEPT ANALYSIS BASED ON BONIS (2013)**

| Step | Method |
|---|---|
| A | Identify the concept of interest |
| B | Identify surrogate or similar themes |
| C | Choose sources of data collection, including time frame and databases from appropriate disciplines |
| D | Data collection |
| E | Thematic analysis |
| F | Thematic plotting |
| G | Article source identification |
| H | Collect data relevant to identify attributes, antecedents, and consequences of the concept |
| I | Analyze data regarding attributes, antecedents, and consequences of the concept |
| | **Results** |
| J | Identify an exemplar of the concept from nursing/health sciences |
| | **Discussion** |
| K | Identify implications for health sciences |
| L | Identify study limitations |

Katz et al. (1959). This narrow conceptualization has, however, been criticized (Braun et al., 2013). Since the publication of Engel's (1981) biopsychosocial model, it has been recognized that health professionals' focus should no longer lie solely on patients' somatic symptoms. The dimensions of the Health Belief Model, which influence health-related behavior (Janz & Becker, 1984), also overlap with the dimensions of psychosocial health. The concept of psychosocial health is, moreover, applied either subconsciously or consciously in the daily practice of health professionals (e.g., regarding the ADL Index); however, a consensus on its conceptualization is lacking.

Several authors agree on the difficulty of conceptualizing the psychosocial, as it seems to be an "intertwined entity, with all the imponderables it raises" (Frosh, 2003, p. 3; Martikainen et al., 2002). This difficulty conceptualizing could be one reason for the lack of clarity associated with the term (Baumeister & Bengel, 2007; Martikainen et al., 2002). In addition, a general definition of psychosocial health for the health sciences is missing in the literature. Regarding the health professions, a clear, distinct, and consistent understanding of psychosocial health and its determinants is essential and would contribute to the clarity of language as well as prevent further random and unspecified use of the term. Furthermore, a clearer conceptualization of psychosocial health and its determinants could assist health professionals as well as patients in thinking through these complex issues and therefore has the potential to promote the psychosocial health of patients as well as health professionals. To address lack of clarity and information in the literature, the current study's aim was to conduct a concept analysis to identify the attributes, antecedents, and consequences of psychosocial health within the field of the health sciences.

## METHOD

### Design

The current concept analysis used a methodology based on Bonis (2013) due to the interdisciplinary nature of the topic. The analysis was therefore performed in accordance with the steps (**Table 1**) outlined by Bonis (2013).

### Data Collection

A systematic literature search was conducted following Steps A to D, as outlined by Bonis (2013). Therefore, *psychosocial health* or *psycho-social health* were used as keywords and combined with other search terms (e.g., *definition*, *meaning*) to ensure that the literature search was focused specifically on definitions (**Table A**, available in the online version of this article). This systematic literature search was conducted separately by two researchers (K.A.P., C.G.). To find all relevant literature, sources of data collection from disciplines, such as medicine, nursing, mental health, public health, philosophy, psychology, sociology, and epidemiology, were used (e.g., PubMed, CINAHL, Cochrane, PsycInfo, Annual Review of Organizational Psychology and Organizational Behaviour).

Titles of all articles were initially screened for their relevance regarding psychosocial health ($N$ = 10,566) (**Figure 1**). If the title of the article was linked to psychosocial health (e.g., the term psychosocial was mentioned in the title), the abstract was then read ($n$ = 238). If the abstract contained no clear reference to psychosocial health, the article was excluded ($n$ = 161). In a further step, 77 full-text articles were independently assessed by two different researchers to determine their fit with the inclusion criteria (article includes a definition of psychosocial health, published in English or German). During this step, another 35 articles were excluded, either because their main focus was not on psychosocial health (e.g., definition focused on psychosocial with no clear relation to health), or because a specific definition as to what psychosocial health meant, in general, was lacking. In the next step, 42 relevant articles that contained definitions regarding psychosocial health were included. Each article was read sepa-

rately by two researchers to reduce interpretation bias. In addition, each of these 42 articles was discussed among the research team regarding how psychosocial health was defined within the article. A total of 27 articles contained a definition of psychosocial health, which referred to another primary source (e.g., quotation), and were, therefore, also excluded. Finally, 15 articles containing their primary published definition were included in the analysis process.

### Data Analysis

In accordance with the methodology of Bonis (2013), each of the 15 articles was reviewed to identify the originating discipline of the definition of psychosocial health. The specific use of the term within its discipline (regarding the characteristics of its definition) was also included. In addition, the discipline of the first author was identified.

In a next step, all data relevant to the identification of attributes, antecedents, and consequences regarding psychosocial health were analyzed. Relevant attributes were collected and thematically plotted into different properties. These properties were thematically summarized in the following process: collecting and documenting, grouping into similar themes, and summarizing. These steps were discussed among the research team.

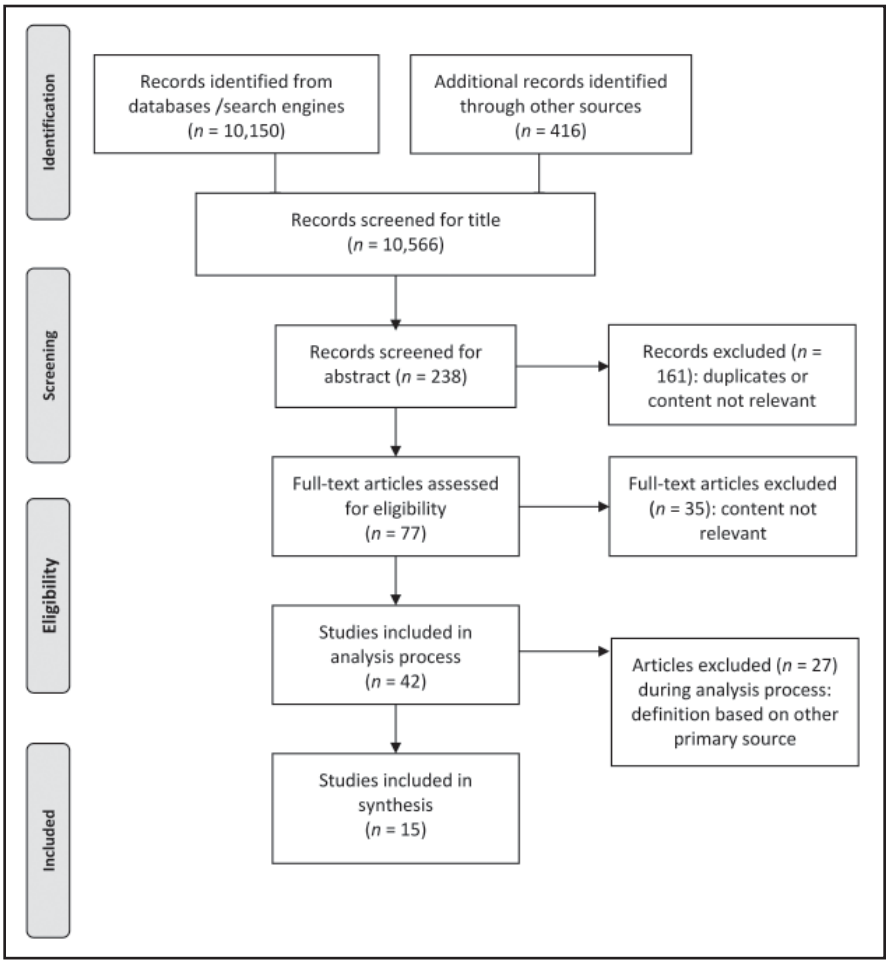


**Figure 1.** Flowchart of study selection.

## RESULTS

**Table B** (available in the online version of this article) presents the identified attributes used to describe the term psychosocial health in the 15 articles included in the current study (Step I). We also tried to identify the discipline (e.g., Professor in Social Sciences or Medicine) to which each first author of the 15 articles belonged (using Google). The first authors of included articles came from the following disciplines: psychology, medicine, public health, nursing, mental health, epidemiology, social sciences, public administration, psychosocial studies, sociology, social and behavioral health sciences, health psychology, psychosocial work environment research, and ethics. However, in most articles, the discipline of origin could not be clearly determined, as the articles were either written with a multidisciplinary focus, or it was not possible to determine the first author's specific discipline.

### Attributes of Psychosocial Health

The central attributes of the concept psychosocial health were identified under the following aspects: (1) individual level, (2) social level, (3) relationship between individual and social levels, (4) material resources, (5) spirituality, and (6) time and chance. For a more detailed description, see **Table B**. Due to the complexity at the individual and social levels, these two levels were further categorized into properties (see below).

*Individual Level Attributes.* Individual level attributes were thematically summarized and included physical or biological aspects, the experience and perception, psychological or mental processes, and the behavior and lifestyle of a person.

Physical or Biological Aspects. Many authors described attributes of psychosocial health at the individual level as being associated with physical or biological properties. Physical or biological attributes were viewed as either being an influencing factor on psychosocial health, or as being an integral part of their definition. In the articles, the following terms were used to describe physical or biological attributes with a focus on characteristics and functions of the human body: cells, tissues, molecules, nervous or organ system, physical func-

tioning, as well as biological responses to human interactions (Baumeister & Bengel, 2007; Borrell, 2005; Egan et al., 2008; Engel, 1981; Evans, 1971; Krieger, 2001a; Macleod & Davey Smith, 2003; McCubbin & Labonte, 2002; Muntaner & Chung, 2005; Rugulies, 2012; Spicer & Chamberlain, 1996). Engel (1981) provided the following examples:

> Cell, organ, person, family, each indicate a level of complex integrated organization about the existence of which a high degree of consensus holds (…) System cell is a component of systems tissue and organ and person. Person and two-person are components of family and community. In the continuity of natural systems every unit is at the very same time both a whole and a part. (pp. 105–106)

Experience and Perception. According to McCubbin and Labonte (2002), "experiences of individuals as social actors directly influence health, and somehow such experience itself is transformed or interpreted within individuals to create varying health outcomes" (p. 51); however, other authors describe the individual level properties of experience and perception, psychological/mental processes, and behavior and lifestyle as unfolding in an individual and in a sequential order, whereby the individual's experience and perception (experience as a social actor) lead to their interpretation of the experience within the context of their social or psychological world (Engel, 1981; Martikainen et al., 2002; McCubbin & Labonte, 2002).

Psychological or Mental Processes. In the selected articles, all authors included the property of psychological or mental processes and used the following terms: *psychological mechanisms*, *mental health*, *psychological effects*, *psyche*, *mind*, *feelings*, *thoughts*, *psychological world*, *emotional health*, *emotions*, *cognitions*, *psychological constructs*, and *cognitive and emotional processes*. Martikainen et al. (2002) offer the following:

> To our mind, a central constituent of a psychosocial explanation of health is that macro-level and meso-level social processes lead to perceptions and psychological processes at the individual level. These psychological changes can influence health through direct psychobiological processes or through modified behaviours and lifestyles. (p. 1092)

Behavior and Lifestyle. Individuals have certain reactions as a result of these psychological processes, which then lead to the modification of their behavior and lifestyle (Martikainen et al., 2002; McCubbin & Labonte, 2002; Rugulies, 2012). Behavior and lifestyle was associated with the following terms: *health behavior*, *reaction*, *direct behavior*, and *lifestyle* (**Table B**).

*Social Level Attributes*. Regarding the social level attributes, the following two properties were extracted from the selected studies: social relationships and networks, and social structures.

Social Relationships and Networks. Social relationships and networks denote the closer or direct social context of an individual, which is present in interpersonal relationships or dynamics (Martikainen et al., 2002; McCubbin & Labonte, 2002). Social relationships and networks consist of: families, friends, coworkers, religious affiliations, social groups or other networks, and contacts in neighborhoods. Martikainen et al. (2002) describe social relationships and networks as being "manifested in interpersonal relationships" (p. 1092).

Social Structures. Social structures refer to the built systems in society and the cultural environment in which an individual exists (Rugulies, 2012). Social structures can be depicted in the following terms: *society as a whole*, *socioeconomic status*, *social and welfare system*, *political and legal system*, *health care system*, *education system*, as well as *the cultural environment* (e.g., ethnicity, religion). Martikainen et al. (2002) provide the following example: "macrosocial structures relate to ownership and control of land and businesses, legal and welfare structures, as well as distribution of income and other resources between groups and individuals" (p. 1092).

*Relationship Between Individual and Social Level Attributes*. The following terms, extracted from the literature, describe the relationship between the individual and social level attributes, such as their interaction together, being reciprocally associated, being hierarchically arranged, or being combined with one another. Several authors (Borrell-Carrió et al., 2004; Egan et al., 2008; Krieger, 2001a,b; McCubbin & Labonte, 2002) describe this relationship as an interaction between the individual and social level (e.g., interaction of molecular, individual, and social factors described by Borrell-Carrió et al. [2004]). Other authors (Baumeister & Bengel, 2007; Evans, 1971; Rugulies, 2012) depict this relationship as either being reciprocally associated (e.g., individuum as a continuum of psyche, body, family, society, and culture in a reciprocal relationship, according to Evans [1971]), as consisting of a hierarchically arranged system (Engel, 1981), as being a combination of the two (Larson, 1996; Martikainen et al., 2002), or as simply being inevitably connected (Spicer & Chamberlain, 1996).

*Material Resources Attribute*. A further attribute extracted from the selected studies was material resources, which refers to the distribution of material resources, or to the disadvantage of not having material resources. The material attribute appears to be directly related to the psychosocial health of an individual (Macleod & Davey Smith, 2003; Rugulies, 2012; Singh-Manoux, 2003). According to the selected articles, this attribute is associated with the following terms: *distribution of material resources*, *ability to buy material*, *social disadvantage*, and *neo-material* (Macleod & Davey Smith, 2003; Martikainen et al., 2002; Muntaner, 2004; Singh-Manoux, 2003).

*Spirituality Attribute*. In several articles, the spirituality attribute was discussed as a supplemental dimension, as with the biopsychosocial model of Engel (1981). Sulmasy (2002) describes *spirituality* as an individual's relationship to a transcendent, and that it is mostly expressed in religious practice. In the included articles, this attribute

is associated with the following terms: *transcendence*, *attitude*, *religious belief,* or *religious experience*. Sulmasy (2002) describes spirituality as being an internal resource (Larson, 1996).

*Time and Chance Attribute*. The last attribute to be described is time and chance. Time and chance depict the place in time (e.g., status, continuum, life span) in which an individual is situated, or the chance of the occurrence of an event (e.g., a traumatic life event, or something more positive, such as a promotion). In the selected articles, this attribute is associated with the following terms: *present*, *past*, *over time and space*, *across time and place*, *timing*, *causes encapsulated in time* (e.g., loss of job), and *state or continuum* (Baumeister & Bengel, 2007; Egan et al., 2008; Engel, 1981; Evans, 1971; Krieger, 2001a; Muntaner, 2004).

#### Antecedents for Psychosocial Health

In most of the selected studies, the antecedents of psychosocial health are not mentioned in detail; however, Engel (1981) describes existence as a human being and the existence of a social environment as being relevant antecedents. Martikainen et al. (2002) claim that the presence of consciousness is necessary for an individual to interact with their social context. In addition, Egan et al. (2008) mention time as being an antecedent.

#### Consequences/Outcomes for Psychosocial Health

The causal processes of influence and outcome surrounding psychosocial health remain unknown. Martikainen et al. (2002) state, "If we wish to contribute to the development of policy to improve health, the complex combinations of social, psychological and biological processes that contribute to ill-health need to be clarified" (p. 1092). However, McCubbin and Labonte (2002) imply in their article that "causal relationships among most factors and processes are likely to be bidirectional" (p. 57), and that poor health can be seen as a result or consequence of various interacting biological, physical, or social factors. However, some factors may be positively (e.g., social support, social cohesion, social diversity and tolerance) or negatively (e.g., demands at work, effort-reward imbalance, work-private life conflicts, social disadvantage and inequalities) correlated with health outcomes (Baumeister & Bengel, 2007; Egan et al., 2008; Martikainen et al., 2002; McCubbin & Labonte, 2002).

## DISCUSSION

The current study aimed to perform a concept analysis identifying the attributes, antecedents, and consequences of psychosocial health for the health sciences. Despite lack of clarity on the concept in the literature, most studies concurred on one point: psychosocial health is a complex interaction between the psyche and the social (Egan et al., 2008; Frosh, 2003; Groffen et al., 2012; Martikainen et al., 2002), and a separation into independent components is problematic (Spicer & Chamberlain, 1996); however, there are discrepancies in our understanding of how the psyche and the social interact with one another. In this complex interaction, it remains uncertain as to which components are most important at the individual level and in the social environment.

The models of Engel (1981) and Martikainen et al. (2002) were the most detailed among the selected studies. Martikainen et al. (2002) developed a tentative schema, which described the psychosocial pathways hierarchically. This schema suggested a distinction between the micro- (individual), meso- (e.g., family, social networks) and macro- (e.g., legal/welfare and social structures) levels, to "elucidate the role of psychosocial factors in health" (p. 1092). Martikainen et al.'s (2002) model's linear correlation of the psychosocial influencing factors resembles the model of Engel (1981), who is known as the pioneer of the biopsychosocial model. According to Engel (1981), "nature is a hierarchically arranged continuum, with its more complex larger units being superordinate to the less complex smaller units" (p. 103). However, the models differ regarding their assumption of the psychosocial in relation to health (e.g., illness only becomes an issue if the personal level is implicated or illness is due to a complex combination of social, psychological, and biological processes) as well as regarding the causal influence of the biological component.

Engel (1981) mentions the interrelationship of the levels and therefore suggests interactions between the social, psychological, and biological levels. Although there is criticism of this model and its hierarchical linearity (Richter, 1999; Sulmasy, 2002), its position that "no system exists in isolation" (Engel, 1981, p. 106) is fundamental to all other approaches conceptualizing psychosocial health (Krieger, 2001a; Martikainen et al., 2002). Approximately 25 years after Engel's publication, Borrell-Carrió et al. (2004) criticized its linearity and its over-simplification of the complexity of nature. In addition, they also pointed out the impossibility of being aware of all factors that influence or contribute to psychosocial health. As Baumeister and Bengel (2007) mention, it is essential to analyze psychosocial health/health behavior and their influences in the "context of relevant biological, medical and economic variables of the individual" (p. 7).

In the Discussion sections of the articles analyzed, usage regarding the physical and biological properties at the individual level and their relation to health is not consistent. For example, in the biopsychosocial model of Engel (1981), the body is clearly a part of the definition. However, Martikainen et al. (2002) conceptualize psychosocial health as having attributes that "act primarily between the fully social and the fully individual level" (p. 1091). This conceptualization shows that for some authors, the physical or biological property influences psychosocial health, whereas for others this property is an integral part of the concept itself.

Regarding the attribute of spirituality, some authors (Hodgkinson, 2008; Legg,

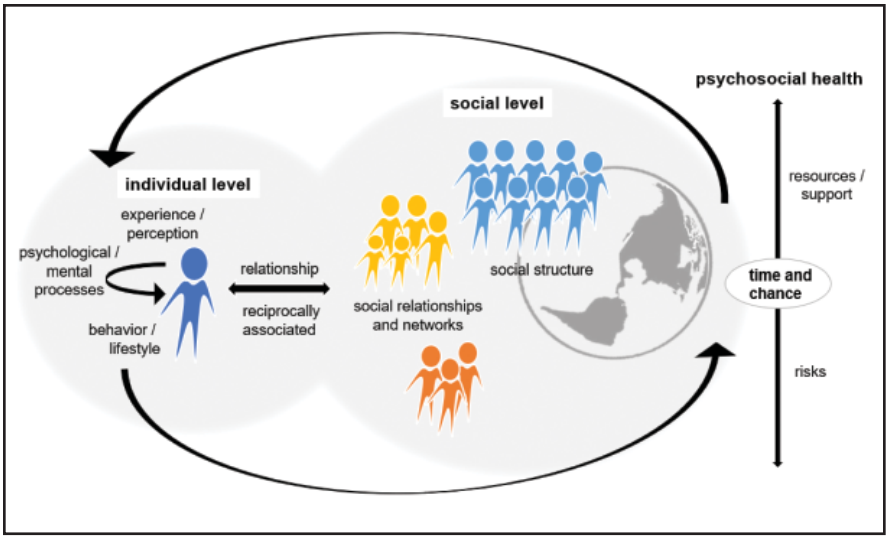


**Figure 2.** Exemplar of the definition of psychosocial health.

2011; Sulmasy, 2002) describe spirituality as being an indispensable part of psychosocial health; however, it is not specifically mentioned by others (Engel, 1981). According to Larson (1996) and Ellison (1991), strong spirituality or religious faith may increase life satisfaction and personal happiness and can reduce the negative consequences of a traumatic experience. According to the authors, spirituality or religious faith can be viewed as either a resource/potential positive influence (e.g., as a coping strategy) or as a risk factor/potential negative influence (e.g., religious compulsion or oppression) for psychosocial health. For example, spirituality could be supportive when coping with traumatic life events; however, religious faith could also prove to be a risk factor regarding religious discrimination or extremist viewpoints. According to Larson (1996), little knowledge exists about the influence of religious faith or experience on health.

### Definition of Psychosocial Health for the Health Sciences

Based on the current concept analysis, a definition of psychosocial health was developed specifically for the health sciences/health professions. The attributes, antecedents, and consequences of this concept, along with discussion of the results of the concept analysis, are as follows.

Psychosocial health is a changing condition that involves the reciprocal adjustment and dependency between an individual and their social environment. The social environment consists of social relationships and networks, such as family, friends, or coworkers, as well as the social structures within the environment.

Psychosocial health depicts a state that is constantly changing (e.g., in different phases of life/life events), and which can either be strengthened through mobilization of resources/support (e.g., emotional support, one's own relational abilities), or weakened through exposure to risks (e.g., stress at work, traumatic event, disease) (**Figure 2**).

The individual level of psychosocial health refers to the experiences or perceptions of a person that affect their psychological and mental processes (interpretation). The resulting behavior/reaction may be expressed in the individual's lifestyle. The body (physical and biological aspects) is seen as an antecedent for psychosocial health and as an influencing factor. These perceptions and interpretations cannot be separated from the body (physical or biological aspects) of the person, as they are necessary for interacting with other individuals, for existing in a social context, as well as for expressing psychological processes through behavior. In addition, the presence of consciousness is essential for a reciprocally associated relationship of the individual and their social context.

The social level of psychosocial health comprises relationships and networks, and includes interpersonal dynamics, which denote the direct social relationships of the individual with others. For example, family, friends, coworkers, and other social networks (e.g., religious institutions, neighborhoods, clubs) are related to social support and social capital. Social structure involves several factors, such as society, socioeconomic structures, political and legal systems, the education system, as well as culture and/or religion.

The material attribute (the ability to buy material goods, the distribution of material resources) and the spirituality attribute (attitude, religious beliefs and experience) can influence health behavior and affect psychosocial health (they are a consequence/outcome of psychosocial health).

In addition, resources/support at the individual or social level can improve the psychosocial health of an individual, whereas risks may diminish psychosocial health. The influence of resources/support and risks on psychosocial health depends on what is occurring at a certain point in time with the individual, as well as what is occurring at the social level (time and chance). Furthermore, the level of influence on psychosocial health depends on the individual's experience/interpretation, as well as on their personal/social resources.

## IMPLICATIONS FOR THE HEALTH SCIENCES

An important question for the health sciences seems to be: How can psychosocial health be addressed and improved in daily practice for patients, as well as for health professionals themselves?

The newly conceptualized definition of psychosocial health, as outlined in the current study, is intended to emphasize how comprehensive and variable psychosocial health can be. As Evans (1971)

emphasizes, a change in one system can affect all the others. This point is relevant for professionals to consider when working with patients, as well as for patients to understand for themselves. How patients view themselves as individuals (Legg, 2011), what is important to them, which skills they have to adapt to their social environment (e.g., after an illness/postnatally), and how their relationships with others are all intertwined and affect their psychosocial health. Integration of such questions during the admission or treatment of patients could assist in supporting patients in improving their psychosocial health and would also be a positive step toward providing more person-centered care in a variety of practice settings and among various health professions.

This newly conceptualized definition also highlights how important relationships are in the social environment. The importance of relationships is also congruent with relevant models, such the Stress Buffering Model and Main Effect Model (Holt-Lunstad et al., 2010). In the first model, the buffering hypothesis assumes that social relationships can provide resources that promote adaptation to acute or chronic stressors (e.g., illness, life events, life transitions). Thus, help from social relationships moderates or buffers the harmful influence of stressors on psychosocial health. The Main Effect Model assumes that social relationships have a protective effect on health through cognitive, emotional, behavioral, and biological influences that are not explicitly intended as help or support. Social relationships, therefore, can directly or indirectly promote or model healthy behavior. Moreover, belonging to a social network gives the individual meaningful roles that can positively influence self-esteem and meaning in life. Therefore, social relationship factors should be routinely included in health evaluations and screenings to improve psychosocial health.

An additional important implication for the health sciences is the relationship between the health professional and the patient (regarding the social context). If the relationship between them is viewed as being reciprocal, topics, such as the influence of health professionals' own state of psychosocial health on patient care (e.g., work-related stress), become relevant. Consequently, caring for others but also self-care on the part of health professionals regarding their own psychosocial health are equally important (Kenny & Allenby, 2012).

The newly conceptualized definition also applies to health promotion and prevention practice. The focus of the definition is on its properties, which can either positively influence (e.g., social capital or resources) or negatively influence (e.g., material and/or social inequalities) the health of an individual directly. In health promotion practice, such properties are referred to as *social determinants of health*, and such social resources can be strengthened through supporting individuals directly, or through targeting, for example, inequities in the social systems (which would indirectly support the psychosocial health of individuals). Prevention of diseases, or supporting individuals who are afflicted with diseases, also directly assists in promoting the psychosocial health of individuals in society. Health promotion focuses its actions on what makes/keeps individuals and society healthy (e.g., supporting positive social resources, reducing negative social influences). Prevention focuses its actions on reducing the impact of illnesses on individuals and society. Thus, focusing on social aspects of health and well-being has major implications for supporting the health of individuals and society.

## LIMITATIONS

The definition of psychosocial health proposed in the current study was developed from existing definitions in various disciplines; therefore, it is not a conclusive definition. Moreover, not all disciplines are closely linked to the health care sector. Therefore, a selection bias could be present regarding sociocultural origins. Due to these potential limitations, the transferability of this definition could be limited. It should also be taken into consideration that the definition may not be equally applicable to all health care professions and areas (e.g., when working with newborn babies or people with dementia). Therefore, this definition requires testing by various health care professionals in their everyday practice and is thus subject to possible modification.

## CONCLUSION

In the current concept analysis, existing definitions of psychosocial health from various disciplines were, for the first time, compiled and analyzed. As a result, an overarching definition for the health sciences was developed that addresses the various aspects of psychosocial health. The definition we propose is comprehensive and should be applicable in a variety of disciplines within the health professions. It should support health professionals in improving psychosocial health for patients and their families. This is important, as a distinct and consistent understanding of the concept of psychosocial health, along with its determinants, has been lacking in the health sciences. In addition, this understanding could help health professionals stay healthy and reduce their stress levels. However, the definition is not exhaustive and requires theoretical and practical evaluation among the various disciplines within the health professions.

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**Table A.** Literature Search

| Search Terms | General Databases/Search Engines | Discipline-Specific Databases | Journals |
|---|---|---|---|
| psychosocial health / psycho-social health<br>**(AND)**<br>measurement / operationalization / components / paradigm / development / content / interpretation / understanding / explanation / approach / origin / meaning / perception / conceptualization / conception / theories / theory / concept / definition / roots / base / basics / basis / fundamental / fundament / strategy / dimensions / perspective / application / attributes / properties / pattern / representation / theoretical account / design / illustration / principle / exemplar / standard / structure / schema / foundation / frame of reference / framing / abstraction / speculation / theorize / construct / description / elucidation / clarifiation / formulation / thought / hypothesis / methodological / determinants | PubMed, CINAHL, Google Scholar, Cochrane, PsycInfo, Web of Science | Annual Review of Organizational Psychology and Organizational Behavior, Annual Review of Medicine, Annual Review of Nutrition, Annual Review of Public Health, MiDIRS, PEDro, PILOTS, Saphir, Termsciences, WHO – Archive, Social Science Research Network, Social Services, IBSS International Bibliography of the Social Sciences, Annual Review of Sociology, Annual Review of Law and Social Science, Ovid Nursing | Psychosozial-Verlag, Journal of Psycho-Social Studies, PsycArticles, SAGE Psychology Science, SAGE Sociology, WISO, Cambridge Books Online, Informa Healthcare, SAGE Health, Free Medical Journals and MedPilot - Virtuelle Fachbibliothek Medizin (Livivo) |

**Table B.** Identified Attributes of Psychosocial Health

| Source | | Individual level | | | | Relationship | Social Level | | Mat-erial | Spir-itual | Tim e | Relation to Health/Illness |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | phy. | exp. | psy. | beh. | | soc net. | soc struc. | | | | |
| 1 | Baumeister and Bengel (2007) | X | X | X | X | Reciprocally associated | X | X | | | X | 'We have defined health in terms of bio-psycho-social aspects of health. This definition shows an overlap with the term psychosocial (Baumeister & Bengel, 2007, p. 6) Psychosocial correlates of health and health behaviours can be seen as causal to health (risk and protective factors), an effect of health (health outcomes), determined by a third variable, correlated by chance as well as reciprocally associated.' (Baumeister & Bengel, 2007, p. 7) |
| 2 | Borrell-Carrió et al. (2004) | X | | X | X | Interaction | X | X | | | | 'The appearance of illness results from the interaction of diverse causal factors, including those at the molecular, individual, and social levels. And the converse, psychological alterations may, under certain circumstances, manifest as illnesses or forms of suffering that constitute health problems, including, at times, biochemical correlates.'(Borrell-Carrió et al., 2004, p. 577) |
| 3 | Egan et al. (2008) | X | X | X | X | Interaction | X | X | X | | X | (…) 'the way peoples' interactions with their social environments may influence health either directly (e.g. through biological responses to what is commonly called 'stress') or indirectly through health behaviours.' (Egan et al., 2008, p. 240) Egan et al. (2008, p. 243) stated that 'health effects included social, psychological, and physical effects that could be measured on humans and health behaviours.' |
| 4 | Engel (1981) | X | X | X | X | Hierarchically arranged system | X | X | X | | X | 'Nature is a hierarchically arranged continuum, with is more complex larger units being superordinate to the less complex smaller units.' (Engel, 1981b, p. 103) 'Note that while changes were taking place at the levels of tissue, cell, molecule, organ, organ system, and nervous system, illness and patienthood did not become issues until the person level was implicated, that is, not until something untoward was experienced or some behavior or appearance was interpreted as indicating illness.' (Engel, 1981b, p. 110) |
| 5 | Evans (1971) | X | | X | | Reciprocal relationship | X | X | | | X | Evans (1971) describes the person as a continuum of psyche, soma, family, society and culture, all in reciprocal relationships and in constant state of interaction with each other. A change in one system affects all the others. |
| 6 | Krieger (2001) | X | X | X | X | Human interactions with one anonthers | X | X | X | | X | 'A psychosocial framework directs attention to both behavioural and endogenous biological responses to human interactions (…) its central hypothesis is that chronic and acute social stressors: (a) alter host susceptibility or become directly pathogenic by affecting neuroendocrine function, and/or (b) induce health damaging behaviours (especially in relation to use of psychoactive substances, diet, and sexual behaviours)' (Krieger, 2001, p. 696). |
| 7 | Larson (1996) | | X | X | X | Combination | X | X | | X | | 'Psychosocial health combines mental and social well-being and clearly places the locus of health with the individual. Psychosocial health should include aspects of social well-being which originate in the individual, such as the individual's social adjustment and response to the environment.'(Larson, 1996, p. 184) |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 8 | Macleod and Davey Smith (2003) | X | | X | X | N/A | X | X | X | | | (…) 'we consider psychosocial factors to be any exposure that may influence a physical health outcome through a psychological mechanism.'(Macleod & Davey Smith, 2003, p. 565) |
| 9 | Martikainen et al. (2002) | X | X | X | X | Complex combination | X | X | X | | | (…) 'complex combinations of social, psychological and biological processes that contribute to ill-health' (Martikainen et al., 2002, p. 1093) (…) it is still unclear what the exact contribution of psychosocial processes are in explaining incidence of disease. (Martikainen et al., 2002, p. 1092) |
| 10 | McCubbin and Labonte (2002) | X | X | X | X | Interaction in a dynamic way | X | X | X | | | 'However, as this century has progressed, so has our realization that the social environment—including cultural, economic, political, interpersonal dynamics and social structural factors—plays a much larger, as well as more complex, role in influencing health and illness than earlier understood.'(McCubbin & Labonte, 2002, p. 48) |
| 11 | Muntaner (2004) | X | | X | | Complex relation | X | X | X | | X | 'Psychosocial constructs are expected to provide generalised risk factor associations across time and place, ignoring the determining social structure. (…) In order to provide accurate accounts of how society affects health, historical and structure-less psychosocial constructs ('social capital', 'sense of coherence', 'hostility', 'life events', 'job stress', 'social support'…) should be replaced with less ideological, historically (e.g. age-period-cohort) specific models in which social structure and psychosocial exposures are integrated into mechanisms that influence population patterns of morbidity and mortality. (Mutaner & Chung, 2005, p. 540) |
| 12 | Ogden (1997) | X | X | X | X | Complex interplay | X | X | | | | 'Factors such as behaviours, beliefs and stressors are not presented as alternatives but as facilitating existing medical causes, the real precipitants. Smoking as a behaviour does not cause lung cancer, it simply provides a medium for exposing the individual to carcinogens.<br>A psychological approach to etiology is not a substitute for medical causes of health and illness.' (Ogden, 1997, p. 24) |
| 13 | Rugulies (2012) | X | X | X | X | Bidirectional associations | X | X | X | | | (…) it is even more important to be aware that psychosocial factors originate from societal structures and social contexts. Understanding these structures and contexts, their changes over time, and their relation to psychosocial factors is key for understanding the effect of psychosocial factors on health and illness. (Rugulies, 2012, p. 620) |
| 14 | Sulmasy (2002) | X | X | X | X | Intrapersonal and extrapersonal relationships | X | X | | X | | Sickness, rightly understood, is a disruption of right relationships. (…) One can say that illness disturbs relationships both inside and outside the body of the human person. Inside the body, the disturbances are twofold: (a) the relationships between and among the various body parts and biochemical processes, and (b) the relationship between the mind and the body. Outside the body, these disturbances are also twofold: (a) the relationship between the individual patient and his or her environment, including the ecological, physical, familial, social, and political nexus of relationships surrounding the patient; and (b) the relationship between the patient and the transcendent. (Sulmasy, 2002, pp. 25-26) |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 15 | Spicer and Chamberlain (1996) | X | X | X | | Components are inevitably connected | X | X | | | | Spicer and Chamberlain (1996) discussed two strategies for combining the psychological and social in health-psychology theories.<br>Integrative strategy: The integrative strategy involves taking familiar types of psychological construct and reconstructing them in a more social form. (…) These constructs are taken to be stable structures which exist inside the person and which have causal influences on behaviour and health. (Spicer & Chamberlain, 1996, p. 167)<br>Transcendent strategy: 'health and disease may be explained in the patterning of relationships between individuals and their social world' (…) 'clearly transcends the psychological and social by making them two parts of one Phenomenon' (Spicer & Chamberlain, 1996, p. 169) |

Note. phy. = physical / biological, exp.= experience / perception, psy. = psychological /mental, beh. = behaviour / lifestyle, soc net. = social relationships and networks, soc. struc.= social structure, material = material / economic, time = time / chance.