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Salutogenesis: Implications for Maintaining a Psychologically Informed Physical Therapy Practice

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INTRODUCTION

Pathogenesis is the study of disease origins and causes, and has been the prevalent approach in Western medicine. It looks retrospectively at how to eliminate illnesses once they occur. Its prospective opposite, salutogenesis, studies health origins and causes, and considers how health is promoted. This theory was developed by Aaron Antonovsky, a medical sociologist working in the late 1970s, who believed there were health promoting behaviors that should be understood and supported in order to supplement the knowledge of disease and pathology.[1-2] The salutogenesis model can help physical therapists bridge the gap between physical and psychosocial interventions.[3] A variety of psychosocial instruments have been used to measure the personal assets that influence salutogenesis.[2] Although physical therapy educators and researchers have recently described the importance of a psychologically informed practice, components of the salutogenic model of health have rarely been studied in physical therapy settings.

Our literature review evaluated twenty-five psychological constructs identified by Lindström and Eriksson[2] within the salutogenic model. Constructs were evaluated based on: **1) measurability**, reflected by the reliability and validity of the instruments used to evaluate the construct; **2) relevance** to physical therapy; and **3) practicality** of use in physical therapy. Constructs were considered relevant if they addressed learnable skills that can be affected by physical therapy. Constructs were considered feasible if they could be measured by physical therapists in a clinical setting using common practice patterns. The authors subjectively determined the criteria of relevance and practicality for this review. Of the twenty-five constructs evaluated, only three exhibited acceptable measurement properties and were deemed relevant to physical therapy practice, and feasible in a clinical setting.

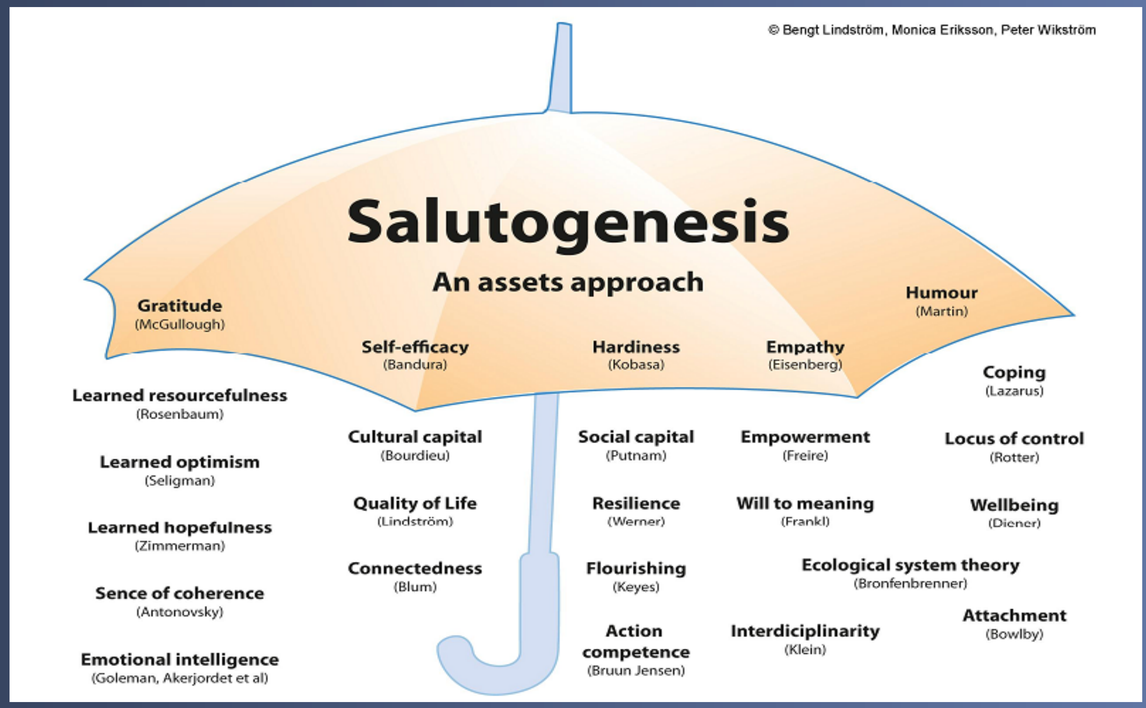

Figure 1: The twenty-five psychological constructs identified by Lindström and Eriksson and considered for this review.[2]

SELF-EFFICACY

Self-efficacy is "a person's belief in their capability to produce a given attainment."[4] High self-efficacy has been correlated with mobility after strokes, improving pain beliefs and symptoms, initiating exercise behavior, and improving patient's self-management of chronic conditions. Self-efficacy can be reliably measured for multiple populations. Interventions to improve self-efficacy that are applicable to a physical therapist's daily practice include: vicarious experience, mastery experience, and increasing social support.[5] Recognition of patients with low self-efficacy may assist in identifying the need to address self-efficacy in a rehabilitation. This review suggests there is potential for use of self-efficacy within physical therapy practice.

RESILIENCE

Resilience is operationally defined, as "the process of effectively negotiating, adapting to, or managing significant sources of stress or trauma."[1] Our review concluded that resilience has been positively linked with exercise levels and patients' perceptions of their functional abilities. The U.S. Army implements "Master Resiliency Training" for all Army officers, with their research showing that resilience and psychological health was improved with the training. The success of that program suggests that resilience is trainable. Such training might add value for rehabilitation professionals, who, theoretically would then be better prepared to educate patients on methods for improving their resilience.

SENSE OF COHERENCE

As originally defined, sense of coherence (SOC) was created as a construct to measure salutogenesis. Meaningfulness, comprehensibility and manageability of a patients health status are the three components of SOC. Although SOC has not directly been studied in PT, it has been found to improve mental health, but has inconsistently improved physical health.[6] Studies have suggested that SOC can be manipulated in the short term but does not create lasting results. This suggests that continued research would be beneficial to determine possible intervention strategies for SOC in a physical therapy setting.

CONCLUSION

The results of this review suggest the potential use of self-efficacy, resilience, and sense of coherence in physical therapy. Evaluating one or more of those constructs might provide physical therapists relevant psychosocial information about their patients and better inform intervention choices. For example, low self-efficacy scores at intake should prompt the clinician to address self-efficacy through education and interventions that promote it. In the absence of self-efficacy evaluation, the clinician might prescribe interventions that exceed the patient's psychosocial resources. The clinician might also have missed the opportunity to educate the patient in a way that promotes self-efficacy and, thus, self management of their condition. To maintain a psychologically informed practice, additional research should be conducted regarding the effect of these salutogenic measures on physical therapy outcomes.

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