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Sense of coherence as a personality predictor of the quality of life in men and women after myocardial infarction

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Abstract

Background: The vast majority of research on the quality of life (QoL) after myocardial infarction (MI) concentrates on such factors as: the type and course of MI, methods and stage of treatment or the patient's occupational and family status. Drawing from general psychological knowledge we may assume that some individual factor, especially personality, is also a significant contributor. The present study focused on a specific personality dimension: sense of coherence (SOC). It is defined as a global life orientation to perceive life as comprehensible (rational, predictable and structured), manageable (adequate and sufficient resources to overcome adversities are perceived as available) and meaningful (the demands created by adversities are seen as challenges and worthy of engagement).

Aim: To compare the QoL one year after MI in men and women and to examine the role of SOC as a predictor of the QoL one year after MI, in groups of men and women.

Methods: The study group consisted of 83 participants (including 34 women), aged 35–59 (50.2 ± 6.2) years. They had a history of uncomplicated MI and were referred for post-hospitalisation cardiac rehabilitation in the sanatorium setting. SOC was measured with the Polish version of SOC-13 by A. Antonovsky. The QoL was evaluated with the MacNew questionnaire by N.B. Oldridge and L. Lim. The SOC was assessed during the stay at the heart centre. One year after their MI the participants completed the QoL questionnaires (sent to them by post).

Results: Men in comparison to women demonstrated stronger SOC ($p < 0.004$) and a better QoL in all dimensions: physical ($p < 0.001$), emotional ($p < 0.001$), social ($p < 0.001$) and as a global score ($p < 0.001$). The SOC turned out to be a significant predictor of the QoL one year after MI even after controlling for demographic and medical factors. Its predictive value was higher for women.

Conclusions: Research on the QoL in patients after MI should take into account personality factors. The SOC is a significant predictor, especially in women. Persons after MI scoring low on SOC at the early stage of rehabilitation should receive psychological intervention.

Key words: sense of coherence, personality, gender, quality of life, myocardial infarction

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INTRODUCTION

There has been an increasing number of publications on the quality of life (QoL) following myocardial infarction (MI) in the recent years [1–3]. Most of these studies, however, focus on such QoL determinants as: the type and course of MI, methods and stage of treatment or the patient's occupational and family status. On the other hand, general psychological knowledge suggests that human responses also depend on individual factors with personality playing a major role [4]. A review of studies on QoL in post-MI patients clearly shows also that the study populations are dominated by men.

The concept of sense of coherence (SOC) has been developed by Antonovsky [5, 6], who defines SOC as "a global orientation that expresses the extent to which one has a pervasive, enduring though dynamic feeling of confidence that: (i) the stimuli deriving from one's internal and external environments in the course of living are structured, predictable and explicable (comprehensibility); (ii) the resources are available to one to meet the demands posed by these stimuli (manageability) and (iii) these demands are challenges, worthy of investment and engagement (meaningfulness)" [5].

Quality of life is the other key concept in current research. This term is variably defined in the literature [2, 7, 8]. Medical studies, including cardiology studies, refer mainly to health-related QoL (HRQoL). Despite certain differences in definitions three its aspects — the physical, mental/emotional and social ones — are most commonly addressed. The physical aspect includes: disease symptoms, particularly pain, functional performance, scope of the activities of daily living the patient is capable of performing, and the level of general vitality. The mental/emotional aspect of HRQoL includes cognitive and emotional functions. The social dimension refers to the scope of professional, family and social roles [2, 8]. In the present paper we have adopted the above concept of HRQoL.

Schweikert et al. [9] assessed HRQoL in 2,950 patients (including 2,341 men) with a history of MI in the previous few years *vs* general population. A large epidemiological programme, MONICA/KORA, aimed at determining the risk factors of cardiovascular disease, was used for this purpose. Post-MI patients showed a significantly worse HRQoL compared to the control group. Post-MI women had a worse HRQoL than post-MI men. It was demonstrated that predictors of HRQoL also included: older age, diabetes mellitus, high body mass index, smoking and another MI. This study did not, however, examine psychological determinants of HRQoL.

Canadian researchers examined the clinical, demographic and psychosocial predictors of HRQoL in 58 patients six months and one year after MI [10]. Predictors of the physical and mental dimensions of HRQoL and general health perceptions were similar six months and one year after MI. Age and undergoing coronary artery bypass grafting (CABG) in the meantime were determinants for the physical dimension of HRQoL. The level of depression before being discharged from hospital was a predictor for the mental dimension and age was a predictor for general health perceptions. The study did not, however, address any aspect of personality as an HRQoL predictor.

On the other hand, Dantas, Motzer and Ciol [11] investigated whether SOC explained the additional percent of HRQoL variance in patients who had undergone CABG, when controlling for clinical, demographic and environmental variables. The study included 84 subjects (including 17 women) who had undergone CABG between one to two (mean: 1.63) years prior to the assessment of HRQoL. The results showed a strong relationship between SOC and HRQoL ($r = 0.72$). Stepwise regression analysis showed that after taking into consideration all the controlled variables SOC yielded a 6% increase in the explained variance of HRQoL. The authors did not, however, state whether similar relationships were present in women and men. Certain limitations for drawing conclusions from this study result from its cross-sectional design. Prospective studies provide much stronger arguments, and it is the prospective design that has been employed in our study.

The aim of our study was to find out whether it is possible to predict HRQoL one year after MI based on the assessment of the personality dimension SOC. We also investigated whether men differ from women in this respect.

METHODS

Study sample

The HRQoL questionnaire was sent to 170 patients. A total of 83 patients sent back a completed questionnaire. The remaining patients failed to respond despite repeated reminders sent to them. The reasons are unknown. This study initially included 170 patients with a history of first uncomplicated MI who were receiving cardiac rehabilitation at a sanatorium. The SOC as well as sociodemographic and medical characteristics were assessed. However, the final analysis included 83 patients: those who sent back completed HRQoL questionnaires one year following their MI. The participants who were not included in the final analysis ($n = 87$) did not differ from the principal group ($n = 83$) in the level of SOC ($F = 0.03$, $p > 0.05$) or sociodemographic and medical characteristics with the exception of the duration of hospitalisation with the former being slightly longer hospitalised ($F = 5.31$, $p < 0.02$, the respective mean values 9.7 ± 6.9 *vs* 7.8 ± 6.9 days). In view of the above only the principal group was further investigated.

The study subjects were aged 35–59 (mean: 50.2 ± 6.2) years and included 34 women aged 38–58 (mean: $51.0 \pm \pm 5.5$) years and 49 men aged 35–59 (mean: 50.0 ± 6.5) years. These subjects, after suffering their first uncomplicated MI, were undergoing post-hospitalisation cardiac rehabilitation at a sanatorium. The mean duration of hospitalisation

was 9 ± 5 days with no differences between men and women. A vast majority of patients (83%) had undergone percutaneous coronary intervention (PCI). Compared to men, women had significantly higher numbers of co-morbidities and performed less advanced exercises during rehabilitation. Compared to women, more men were married, employed before their MI and held a college or university diploma.

Description of research tools

The SOC was assessed with SOC-13 questionnaire developed by Antonovsky [5, 12–14]. The questionnaire consists of 13 items which are rated by the patient on a 5-point Likert scale. A higher score means a stronger SOC. The Polish version of SOC-13 is characterised by good psychometric parameters [15]. In our study, reliability assessed with Cronbach's alpha was very good and equalled 0.85 for women and 0.83 for men.

The HRQoL was assessed with the MacNew questionnaire dedicated for the specific assessment of HRQoL of cardiac patients [16, 17]. The questionnaire consists of 27 questions making up three QoL dimensions: physical, emotional and social. Respondents answer the questions using a 7-point Likert scale. The results are calculated for each dimension separately, in accordance with the key. It is also possible to determine a global score. The reliability and validity of MacNew and its Polish version are good to very good [16–18]. In our study, Cronbach's alpha coefficients of reliability were very good and equalled 0.87–0.94 for women and 0.95–0.97 for men.

Procedure

Participation in the study was voluntary. The SOC-13 was completed by patients on their own, during their stay at the post-hospitalisation cardiac rehabilitation facility. The MacNew questionnaire along with a stamped and addressed return envelope was sent out by post to the study participants one year after their MI.

Statistical analysis

We used the following methods in our study: analysis of variance, r-Pearson's correlation analysis and multivariate regression analysis.

RESULTS

At the beginning of the analysis women and men were compared in terms of SOC and HRQoL. The next step involved determining the degree to which the controlled sociodemographic and medical variables affected the level of SOC and HRQoL. This was followed by examination of correlations between SOC and HRQoL, separately for women and men. It was then determined which of the variables (sociodemographic and medical factors and SOC) were HRQoL predictors one year after MI, separately for women and men. In the study group, the level of SOC was significantly higher in men than in women ($t = 3.02$, $p = 0.004$) with the respective M values of 45.95 ± 6.34 and 41.05 ± 7.81. The differences between men and women in the QoL are illustrated in Figure 1.

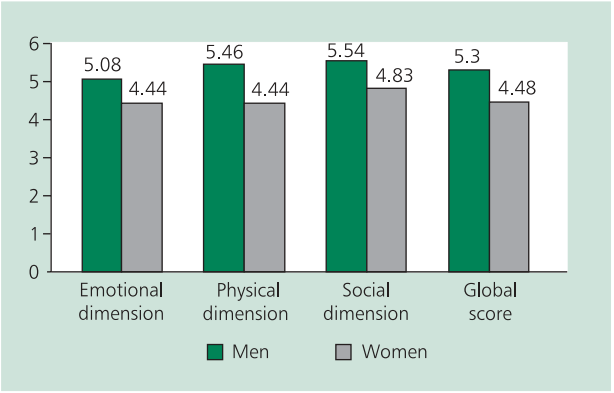

Figure 1. Quality of life one year after myocardial infarction in the group of women (n = 34) and in the group of men (n = 49)

Compared to women, men were characterised by a better HRQoL in all dimensions. These preliminary results suggested the necessity to carry out further statistical analyses separately for women and men.

First, however, we determined whether the controlled secondary variables affected the results for primary variables (SOC and HRQoL). As regards women, marital status and intensity of exercises were significantly associated with the physical dimension of HRQoL. Married women ($F = 5.59$, $p = 0.02$) and women pursuing a more intensive exercise programme ($F = 4.79$, $p = 0.02$) had a higher QoL. These factors were also associated with the social dimension ($F = 5.87$, $p = 0.02$ and $F = 4.62$, $p = 0.02$, respectively). Treatment with beta-blockers correlated with a higher HRQoL in the emotional dimension ($F = 4.87$, $p = 0.04$), while women with a college/university degree had significantly higher SOC compared to women with secondary-level education ($F = 5.31$, $p = 0.01$).

Among men, better functioning in the physical dimension was associated with college/university-level education ($r = 0.30$, $p = 0.03$), treatment with beta-blockers ($F = 4.96$, $p = 0.03$) and the intensity of exercises (a statistical trend, $F = 3.05$, $p = 0.06$). There was also a statistical trend in the relationship between the intensity of exercises and the social dimension ($F = 3.28$, $p = 0.06$).

The results on the effect of the controlled secondary variables on the primary variables confirmed the necessity to carry out separate analyses for women and men. The next step was to determine the correlations between SOC and HRQoL (Table 1).

Table 1. Correlations (Pearson's r and p value) between sense of coherence and the quality of life in women (n = 34) and men (n = 49)

Sex	MacNew global score	Emotional dimension	Physical dimension	Social dimension
Women	0.68 (0.001)	0.73 (0.001)	0.58 (0.001)	0.65 (0.001)
Men	0.41 (0.003)	0.55 (0.001)	0.28 (0.05)	0.30 (0.03)

The relationships between SOC measured during the patients' stay at the rehabilitation facility and the HRQoL dimensions one year after MI were statistically significant both in the group of women and in the group of men, except that the correlation coefficients were higher in the group of women. The correlation coefficients in the group of women suggested strong relations, while those in the group of men pointed to weak to moderate connections. The higher the SOC, the better the HRQoL one year after MI.

These relationships are linear and do not take into account simultaneous effects of other variables. In order to determine to what degree SOC might be a predictor for individual dimensions of HRQoL we performed multivariate regression analysis. We used the stepwise approach, including in the model those sociodemographic and medical variables in the first step which significantly correlated with the outcome variable (described above). The SOC was included in the second step. This way the predictive power of SOC was defined after taking into consideration the significance of the controlled variables.

Table 2 summarises the results obtained in the group of men, for each of the HRQoL dimensions separately. Significant HRQoL predictors in the physical dimension included level of education (the higher the level of education, the better the functioning), treatment with beta-blockers and exercise intensity. Step 1 variables explain 31% of the variance of this HRQoL index. The addition of SOC to the model results in a statistically significant increase of the explained variance by a further 7%. As regards the social dimension, exercise intensity and SOC were significant predictors with the addition of SOC to the model resulting in an increase of the explained variance by 10%. The only predictor for the emotional dimension of HRQoL in men was SOC. It allowed to explain 30% of the variance of this index.

Table 3 illustrates the results of the regression analysis obtained in the group of women, for each of the HRQoL dimensions separately. The only significant predictor in the physical and social dimensions of HRQoL in women was SOC, which explained an overwhelming majority of variances within these indexes. These results are most likely associated with the fact that simple correlations between the controlled variables and the outcome variables were very weak or had the nature of statistical trends. Also with respect to the emotional dimension of HRQoL the only significant predictor was SOC, whose addition to the model resulted in an increase of the explained variance by as much as 42%. Although a model which took into account beta-blockers in step 1 was also significant, the coefficient of regression for beta-blockers after addition of SOC did not reach the level of statistical significance.

Table 2. Results of stepwise multivariate regression analysis: predictors of the HRQoL dimensions in men (n = 49)

	β	t	F	R^2
Physical dimension				
Step 1:			6.7**	0.31**
Education	0.30	2.29*		
Beta-blockers	0.29	2.25*		
Exercise intensity	0.40	3.22**		
Step 2:			6.78***	0.38**
Education	0.29	2.35*		
Beta-blockers	0.27	2.21*		
Exercise intensity	0.42	3.47**		
Sense of coherence	0.27	2.27**		
Social dimension				
Step 1:			4.33*	0.08*
Exercise intensity	0.29	2.08*		
Step 2:			5.31**	0.18*
Exercise intensity	0.31	2.33*		
Sense of coherence	0.32	2.41*		
Emotional dimension				
Step 1:			20.44***	0.30***
Sense of coherence	0.55	4.52***		

β — coefficient of regression; t — statistic testing the significance of the coefficient of regression; F — statistic testing the significance of the model; R^2 — corrected R-squared; significance levels: *p < 0.05; **p < 0.01; ***p < 0.001

DISCUSSION

Our results indicate that men one year after their MI, compared to women, present a better HRQoL. Our data are consistent with those reported by foreign authors [9, 17, 19]. However, the analyses of our results provide new important information on different HRQoL predictors and HRQoL dimensions in men and women. While both in men and in women SOC is a good predictor of HRQoL one year after MI, its power is different. In all the HRQoL

Table 3. Results of stepwise multivariate regression analysis: predictors of the HRQoL dimensions in women (n = 34)

	β	t	F	R^2
Physical dimension				
Step 1:			1.20	0.07
Marital status	–0.17	–1.02		
Exercise intensity	0.20	1.21		
Step 2:			6.22**	0.38**
Marital status	–0.07	–0.53		
Exercise intensity	0.22	1.55		
Sense of coherence	0.56	3.89**		
Social dimension				
Step 1:			1.87	0.10
Marital status	–0.24	–1.40		
Exercise intensity	0.24	1.38		
Step 2:			9.90***	0.49***
Marital status	–0.12	–0.96		
Exercise intensity	0.25	1.92		
Sense of coherence	0.65	4.83***		
Emotional dimension				
Step 1:			4.87*	0.13*
Beta-blockers	0.36	2.20*		
Step 2:			19.43***	0.55***
Beta-blockers	0.17	1.43		
Sense of coherence	0.67	5.44***		

Abbreviations as in Table 2

dimensions, SOC is a better predictor in women than in men, which is quite surprising if one takes into account the fact that SOC in men is stronger than in women and their HRQoL one year after MI is better than in women. These data become clearer if one looks at the baseline sociodemographic data and the regression analysis results. It turns out that men were better educated than women, more of them were professionally active, had fewer comorbidities and performed more intensive exercises during rehabilitation at a sanatorium. These variables could positively affect HRQoL [2, 9, 11]. At the same time regression analysis results in men indicated that in addition to SOC significant predictors of HRQoL in the physical dimension included: education, exercise intensity and treatment with beta-blockers, and the significant predictor of HRQoL in the emotional dimension was exercise intensity. In the group of women, the initially significant variables (marital status and intensity of exercises performed at the rehabilitation facility) became insignificant for the physical and social dimensions of HRQoL after SOC was taken into account. Similarly, with respect to the emotional dimension of HRQoL in women, the significance of beta-blockers disappeared after SOC was included in the analysis. These data suggest that in men, HRQoL was additionally increased (in addition to SOC) by the intensity of rehabilitation exercises, treatment with beta-blockers and better education. On the other hand, in the women we studied, only SOC played a major role. It may be associated with the fact that in the group of women, the rehabilitation exercises were less varied and their level of education was lower. A question arises to what degree the HRQoL determined one year after MI is the result of post-hospitalisation cardiac rehabilitation at a sanatorium and to what degree it is only associated with the lapse of time. Our study cannot answer this question, as the study lacked a matched control group of post-MI patients who did not undergo rehabilitation. The demonstrated role of rehabilitation exercise intensity for HRQoL in men may suggest that the time since MI alone, without rehabilitation, may be insufficient. Another question is: to what degree the differences in HRQoL determinants in men and women are specific for the study group and to what degree they may also concern other post-MI patients. Further studies in this area are required.

Limitations of the study

There are certain limitations which render any generalisations impossible. The study population was a selected group of post-MI patients: they met specific biomedical criteria which allowed them to participate in post-hospitalisation rehabilitation at a sanatorium. In addition, they accounted for a mere 48.8% of patients who sent back a completed MacNew questionnaire one year after experiencing MI. The HRQoL of the remaining patients is unknown. Also, we have no data regarding the health condition of study subjects one year after their first MI. All these limitations demand caution when interpreting the data.

CONCLUSIONS

1. In the study population, one year after MI, men showed a better HRQoL than women.
2. The SOC, treated as a personality dimension, was a good predictor for HRQoL one year after MI both in women and in men, except that in women, it allowed for a better prediction of HRQoL.
3. In the group of men, good HRQoL predictors one year after MI, in addition to SOC, included: more intensive exercises during rehabilitation at a sanatorium, education and professional activity before MI.
4. Patients with low SOC should receive additional psychological support in the early phases of post-MI rehabilitation.

Conflict of interest: *none declared*

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Poczucie koherencji jako osobowościowy predyktor jakości życia kobiet i mężczyzn po zawale serca

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Streszczenie

Wstęp: W badaniach nad jakością życia pacjentów po zawale serca (MI) najczęściej uwzględnia się jedynie sytuacyjne uwarunkowania, np. rodzaj i przebieg MI, występowanie bólów wieńcowych, metody leczenia, sytuacja rodzinna, zawodowa itp. Jednak to, jak pacjent spostrzega i ocenia własne życie i zdrowie, zależy także od jego osobowości. W niniejszych badaniach uwzględniono poczucie koherencji (SOC) traktowane jako wymiar osobowości. Zgodnie z koncepcją A. Antonovskyego SOC rozumiane jest jako orientacja życiowa, polegająca na spostrzeganiu świata jako zrozumiałego, sterowalnego, mającego sens i wobec tego wartego podejmowania wysiłku oraz inwestowania emocjonalnego.

Cel: W prezentowanych badaniach określano jakość życia u kobiet i mężczyzn rok po pierwszym MI oraz związek między SOC a jakością życia. Sprawdzano, czy relacje te są takie same u kobiet i mężczyzn oraz czy na podstawie SOC można przewidywać jakość życia chorych rok po przebytym MI.

Metody: W badaniach wzięło udział 83 osób w wieku 35–59 lat (50,2 ± 6,2 roku), w tym 34 kobiety. Chorzy ci po pierwszym, niepowikłanym MI uczestniczyli w sanatoryjnej rehabilitacji poszpitalnej, a następnie byli pod opieką lekarzy ogólnych w miejscu zamieszkania. Poczucie koherencji badano za pomocą kwestionariusza SOC-13 Antonovskyego w czasie pobytu chorych w ośrodku rehabilitacyjnym; SOC-13 składa się z 13 prostych pytań, na które osoby badane odpowiadają na 5-stopniowej skali Likerta. Polska wersja SOC-13 charakteryzuje się dobrymi wskaźnikami psychometrycznymi. Jakość życia oceniano rok po MI za pomocą kwestionariusza MacNew N.B. Oldrige'a i L. Lim. MacNew jest specyficznym kwestionariuszem przeznaczonym dla pacjentów kardiologicznych i uwzględnia on 3 wymiary jakości życia: fizyczny, emocjonalny oraz społeczny. Pozwala także na określenie globalnej jakości życia badanej osoby. MacNew składa się z 27 pytań, na które chorzy odpowiadają na 7-stopniowej skali Likerta. Polska wersja MacNew została przygotowana zgodnie z metodologią adaptacji testów psychologicznych, a wskaźniki trafności i rzetelności są zadowalające.

Wyniki: Mężczyźni charakteryzują się silniejszym od kobiet SOC ($p < 0,004$), a rok po MI charakteryzują się lepszą jakością życia w wymiarach: fizycznym ($p < 0,001$), emocjonalnym ($p < 0,001$), społecznym ($p < 0,008$) i w zakresie globalnej jakości życia ($p < 0,001$). Związek między SOC a jakością życia rok po MI był silniejszy u kobiet niż u mężczyzn. Po uwzględnieniu w analizie statystycznej kontrolowanych zmiennych socjodemograficznych okazało się, że SOC jest lepszym predyktorem jakości życia u kobiet niż u mężczyzn rok po MI.

Wnioski: W badaniach jakości życia chorych z MI należy uwzględniać, oprócz zmiennych sytuacyjnych, także zmienne podmiotowe, takie jak płeć i czynniki osobowościowe. Poczucie koherencji traktowane jako wymiar osobowościowy jest dobrym predyktorem jakości życia rok po MI, szczególnie u kobiet. Osoby wykazujące niskie SOC powinny, we wczesnych fazach rehabilitacji po MI, otrzymywać dodatkową pomoc psychologiczną.

Słowa kluczowe: poczucie koherencji, osobowość, płeć, jakość życia, zawał serca

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