

Self-Rated Health and its Relationship to Health/Life Problems and Coping Strategies in Members of the Professional Slovenian Armed Forces

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ABSTRACT

The aim of this study was to test the association between self-rated health status (i.e. psychological and interpersonal welfare, physical health, coping mechanisms) and absence from work due to illness in the Slovenian armed forces. 390 military personnel were included in the study. Two groups of soldiers, healthy (G1-H) and sick/less healthy (G2-S), were created according to the median value of their annual sick leave. A third group consisted of soldiers on a mission (G3-M). A background questionnaire (demographic data, lifestyle habits, a list of life problems and a list of health problems in the last three years), a Self-Rated Health Scale and the Folkman-Lazarus Ways of Coping Questionnaire were administered. Self-rated physical health was best in group G1-H and worst in G2-S, with differences between the groups being statistically significant. No gender differences were found either between the groups or in the whole sample. The most common coping strategies amongst all the soldiers were found to be problem solving, positive re-evaluation of the situation and self-control. The groups differed only in their use of the distancing strategy. The self-rated health of all the participants was found to be in strong negative correlation with the escape/avoidance coping strategy. In group G2-S, more soldiers assessed their health as poor; the differences between the groups were statistically significant. Strong positive correlations between self-rated health and satisfaction with interpersonal relationships were found. Self-rated health was found to be significantly associated with the quality of interpersonal relationships and the socio-economic and psycho-physical conditions of the soldiers.

Key words: self-rated health, stress, coping strategies, bio-psycho-social wellbeing, life problems, health problems

Introduction

Self-Rated Health (SRH) represents people's integral and subjective general assessment of their own health. It reflects their feeling and/or experience of health and incorporates biological, psychological and socio-economic dimensions^{1,2}. This indicator is frequently used in population research and social epidemiology. SRH reflects any present illness, its symptoms, and the risk factors of the disease or the functional status of the individual. The factors influencing SRH are various and include, among other things: age, people's own experience of health, their knowledge of what health means and their ability to cope with life circumstances. Social class has also been shown to influence SRH¹, and it is associated with physical fitness³ and morbidity^{4,5}, as well as being a predictor of mortality⁶⁻⁸. All these factors influence the typical health behaviour of the individual^{9,10}.

SRH is a valid health status indicator for middle-aged groups,¹¹ and it can be used to study the relationship between stress, burnout and working organizational conditions. The validity of SRH can be confirmed by objective assessment methods, for example, by the number of visits to the doctor or absenteeism from work, and, as already mentioned, by mortality. In 2008 Eriksson analyzed the connection between sick leave and low SRH in the Swedish population by using the EQ-5D Questionnaire for Health Assessment¹².

Studies have shown that amongst healthy middle-aged individuals several factors predict SRH: physical and psychosocial working conditions¹³, the economic situation, psychological status, and lifestyle¹⁴. In Slovenia there has only been one epidemiological study conducted on SRH, and it showed some demographic factors con-

nected with poor health ratings, including age over 50, divorce, poor education, and lower socio-economic class¹⁵.

Only a few studies have researched threats, fears or various other psychological problems on SRH. Cognition, beliefs and knowledge of harmful environmental factors and the diseases derived from them are very important factors for developing consciousness of the relationship between health and the environment¹⁶.

SRH is also influenced by perceived threat and stress. Social and environmental factors such as discrimination and violence, lower socio-economic status and a lack of social support operate indirectly through objective health problems, somatic stress, depression and low self-esteem to affect subjective SRH in young immigrants¹⁷. In 2008 Karademas investigated chronic illness as a source of threat and related stress and its impact on low SRH¹⁸.

In the study 'An Analysis of Behavioural Responses and Bio-psycho-social Wellbeing among Members of the Slovenian Armed Forces in Peaceful and Active Duty Circumstances – Coping with Stress and Burn-out', the key psychological factors of people who report lower bio-psycho-social-wellbeing and burnout, and therefore perform with lesser working effectiveness and motivation, were addressed¹⁹.

The present analysis is focused on SRH and its determinants in a group of professional members of the Slovenian armed forces. SRH was established as an integrated experience of health, which identifies how this assessment reflects the stressful conditions and organization of the army through a variety of chronic diseases and disease symptoms.

Materials and Methods

The aim of this study was to test the relationships between Self Rated Health status, including psychological and interpersonal welfare as well as physical health, the most often used coping mechanisms, and data referring to absence from work due to illness.

An overview of the individual's absence from work due to illness (duration, reason) was included in the SRH instrument developed for the study. Absence from work on sick leave was used as a validation criterion of the SRH scale. The data on sickness absence for the period in question was provided by the army with the permission of the participating subjects.

Subjects

The professional Slovenian Army comprised 5908 members at the beginning of 2008. All the soldiers billeted in all three barracks in the central area of Slovenia were invited to participate in the study, and a total of 448 voluntarily agreed. Two groups of soldiers, healthy and sick (less healthy), were created according to the median value of their sick leave, using the average number of days off sick from the Slovenian army in the period 2005–2007 as the criterion.

A third group consisted of soldiers on a mission. To participate in a mission, which represents specific profes-

sional circumstances and a greatly increased level of stress, excellent health status is obligatory. The third group was separated from the first two since the impact of the extremely stressful circumstances of the mission was examined.

Permission was obtained from the Ethical Commission of the Ministry of Health of Slovenia before the research started, on 24th October 2006.

Instruments and measures

The instruments used in this study were the background questionnaire, the SRH scale, and the Folkman-Lazarus Ways of Coping Questionnaire.

The background questionnaire included demographic data (age, gender, education, years of service), lifestyle habits (smoking, use of alcohol), a list of life problems encountered in the last three years and a list of health problems of last three years.

The SRH scale allowed participants to rate their past health on a 5-point scale using a self administered questionnaire, completed separately for each year 2005–2007. The soldiers also assessed their current health in separate bio-psycho-social categories: *mental and physical health, financial situation and current life situation*. The 5-point rating scale for SRH consisted of: 1 – excellent, 2 – good, 3 – medium, 4 – poor, 5 – very poor.

The Folkman-Lazarus Ways of Coping Questionnaire (WCQ)²⁰ measures coping processes and strategies. Coping strategies include all the cognitive and behavioural attempts to restrain a specific external or internal situation, which is assessed as exhausting by an individual, probably outmatching his or her strength. The WCQ consists of 66 items describing stressful situations, and subjects are asked to describe how they reacted using the following scale: 0 – not at all, 1 – partly, 2 – to a considerable extent, 3 – predominantly. Not all items are scored. According to the authors there are 8 main ways of coping with stress: confrontation (aggressive efforts to alter the situation, suggesting some degree of hostility and risk-taking), distancing (cognitive efforts to detach oneself and to minimize the significance of the situation), self-control (efforts to regulate one's feelings and actions), seeking social support (efforts to seek information, tangible support, and emotional support from others), accepting responsibility (acknowledging one's own role in the problem, with a concomitant theme of trying to put things right), escape-avoidance (wishful thinking and behavioural efforts to escape or avoid the problem), problem solving (deliberate problem-focused efforts to alter the situation, coupled with an analytical approach to solving the problem), and positive reappraisal (efforts to create positive meaning by focusing on personal growth, which may also have a religious dimension). The scale has adequate construction validity; it includes action-based as well as emotion-based coping strategies. Moderate internal consistency reliability, ranging from 0.56 to 0.85 for the subscales, was reported by Folkman and Lazarus²⁰.

All the instruments were completed by the participating soldiers at the barracks at the beginning of 2008. Soldiers on a mission (group 3) completed them after returning home.

Statistics

The self assessment questionnaire and the WCQ were interpreted by mean values. The maximum values in the WCQ differ for each coping strategy, so the pondered mean values were calculated.

Nonparametric tests (Kruskal-Wallis, Mann-Whitney) were used to find possible differences between the groups, and correlation coefficients (Kendall’s tau) were calculated to find the nature of the correlation between the variables (SRH and the self-assessment of mental and physical health, overall quality life and financial situation).

Statistical analyses were carried out using the SPSS statistical package (v 17.0, SPSS inc.).

Results

Of the 448 soldiers who agreed to participate, 390 returned completed questionnaires (87% response rate). Of these 342 (87.7%) were men, which is comparable to the total Slovenian army population (86.19% men).

There was no statistically significant difference in age between the men (30.7±7.70) and the women (31.1±7.02) in the sample (Z=-0.66, p=0.510). However, once they were divided into the three groups, there were statistically significant differences in age (χ²=14.62, p=0.001); the less healthy soldiers (G2-S) being the oldest (32.1±7.83), the soldiers in missions (G3-M) the youngest (28.4 ± 5.06), and the healthy soldiers in between (31.7±8.86).

The percentage of regular soldiers in the sample was larger than the percentage of officers, following the general army population (soldiers: 60.0% versus 47.2% in the general army population; non-commissioned officers: 25.1% versus 30.0%; and officers: 14.9% versus 22.8%).

19 (4.8%) participants admitted to 'risk level' alcohol drinking ('risk level' drinking meaning more than 2 units of alcohol per day for men and more than 1 unit per day for women²¹), and 134 (34.4%) participants were smokers: 41 (31.7%) in G1-H, 39 (29.8%) in G2-S and 54 (41.4%) in G3-M.

Self-assessed mental health in all three groups was similar, on average very good (χ²=0.31; p=0.855). Physical health was rated best in G1-H and worst in G2-S, and the differences between the groups were statistically significant (χ²=6.83; p=0.033). The estimate of financial situation was similar across the groups, but only moderately good (χ²=0.05; p=0.974). All three groups evaluated their overall quality of life slightly better than their financial situation, but a little worse than their health (χ²=4.17; p=0.124).

All three groups rated their relationship with their parents as the best; on average, it was awarded a 'good' rating. The second best was their relationship with their partner, and workplace relationships were assessed as only moderately good. There were no statistically significant differences between the groups in assessing their interpersonal relationships (partnership: χ²=1.41; p=0.494, parental: χ²=0.66; p=0.720 and work-related: χ²=5.64; p=0.060).

The most frequently reported general problem in all three groups was financial difficulties, but there were also many reports of problems at work such as disagreement with colleagues and poor material or technical con-

TABLE 1
SELF-ASSESSMENT OF CURRENT MENTAL AND PHYSICAL HEALTH, FINANCIAL SITUATION AND OVERALL QUALITY OF LIFE

	Mental health			Physical health			Financial situation			Overall quality of life		
	M	SD	N	M	SD	N	M	SD	N	M	SD	N
G1-H	4.26	0.83	129	4.26	0.80	129	3.01	1.12	129	3.74	0.91	129
G2-S	4.25	0.88	130	4.05	0.81	130	2.94	1.05	130	3.58	0.81	130
G3-M	4.32	0.79	129	4.05	0.84	129	2.98	1.07	128	3.56	0.90	129
All	4.28	0.83	388	4.12	0.82	388	2.98	1.07	388	3.63	0.88	388

TABLE 2
SELF-ASSESSMENT OF THE MOST IMPORTANT INTERPERSONAL RELATIONSHIPS

	Partnership			Parents			Work-related		
	M	SD	N	M	SD	N	M	SD	N
G1-H	3.86	1.23	124	4.19	1.01	68	3.57	0.92	129
G2-S	3.75	1.18	126	4.30	0.73	69	3.35	0.96	130
G3-M	3.75	1.18	126	4.30	0.73	69	3.35	0.96	130
All	3.76	1.25	372	4.20	0.94	192	3.39	0.98	388

TABLE 3
MOST COMMON COPING STRATEGIES AMONG SOLDIERS

	G1-H			G2-S			G3-M			All		
	M	SD	N	M	SD	N	M	SD	N	M	SD	N
Confrontation	8.17	2.38	130	8.15	2.69	130	8.81	3.10	129	8.38	2.75	389
Distancing	6.38	2.68	130	7.24	2.86	130	7.71	3.24	129	7.11	2.98	389
Self-control	8.12	2.34	130	8.21	2.53	130	8.50	2.77	129	8.28	2.55	389
Seeking social support	8.86	2.87	130	9.14	3.01	130	8.64	3.19	129	8.88	3.02	389
Accepting responsibility	8.61	2.60	130	8.47	3.14	130	8.38	2.93	129	8.49	2.89	389
Escape / avoidance	4.54	3.62	130	5.41	4.35	130	5.92	4.77	129	5.29	4.30	389
Problem solving	11.84	3.19	130	11.34	2.88	130	11.49	3.10	129	11.56	3.06	389
Positive reappraisal	9.45	2.41	130	9.11	2.71	130	9.17	3.01	129	9.24	2.72	389

ditions. Only a few soldiers, all from the group G2-S, stated here that they had had health related problems.

In all three groups general malaise was described as the most common health issue. The most common health problems in G1-H were general malaise, tiredness and sleep disturbances (17.6%). These appeared either isolated or together with others such as allergies, musculoskeletal disorders and neurological symptoms or psychological problems. The most common health problems in G2-S were also general malaise, tiredness and sleep disturbance. They were reported in 19.9% of participants and again appeared either isolated or together with others, listed in declining frequency: musculoskeletal disorders, psychological problems (anxiety, depression) or non-specific neurological symptoms such as headaches, dizziness, tinnitus and poor concentration.

Many health problems appeared together, for example: 9.2% out of the 16.1% of participants who reported musculoskeletal problems also reported tiredness, 3.8% also had non-specific neurological symptoms, and 1.5% of the participants in group G2-S also had psychological problems.

The most common health problem in G3-M was general malaise (20.6%), combined with gastrointestinal problems in 6.1%, with neurological symptoms in 5.3%, and less frequently with the common cold or in a combination of malaise, neurological problems and psychological problems. Musculoskeletal diseases or injuries as a separate health problem were the first complaints amongst the participants on missions (G3-M). In this group injuries were second ranked health problem, while in the other two groups injuries were mentioned much less frequently.

The most common coping strategies reported by the all soldiers in the study were problem solving, positive re-evaluation of the situation, and the search for social assistance. Less frequently, the soldiers used avoidance/escape and distancing. The groups differed only in the use of the distancing strategy, which was used most often in the group G3-M and least in the group G1-H ($\chi^2=13.64; p=0.001$). There were no statistically significant

gender differences between the coping strategies of the soldiers.

The SRH values show that the subjects mostly felt 'good' during the period in question ($M=4.12\pm0.92$). Group G1-H contained the largest proportion of participants who considered that they felt 'great' ($M=4.27\pm0.86$). More soldiers in group G2-S ($M=3.98\pm1.02$) assessed their health as poor or very poor than in the other two groups (G3-M, $M=4.12\pm0.85$). The differences between the groups for 2007 were statistically significant ($\chi^2=6.13; p=0.047$). Women rated their health lower than men, although with no statistical significance.

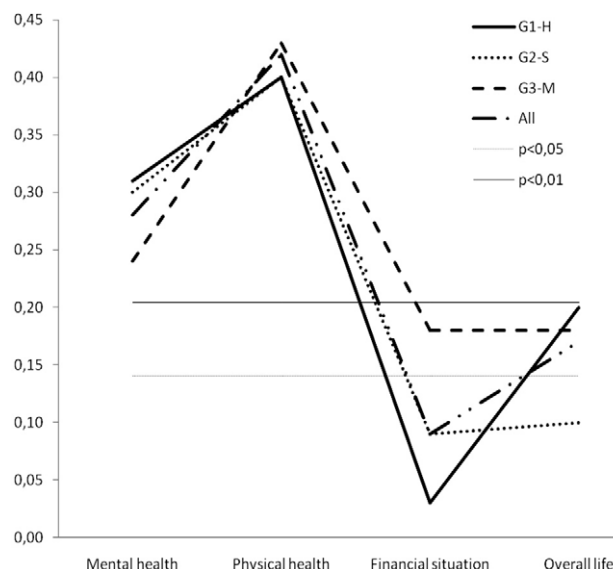


Fig. 1. Correlation coefficients between self-rated health and self-assessment of current mental health, physical health, financial situation and overall quality of life.

Strong positive associations were found between SRH and the participants' self-assessment of mental and physical health and current overall quality of life, and a moderate positive association with their assessment of their financial situation. In all three groups, strong positive

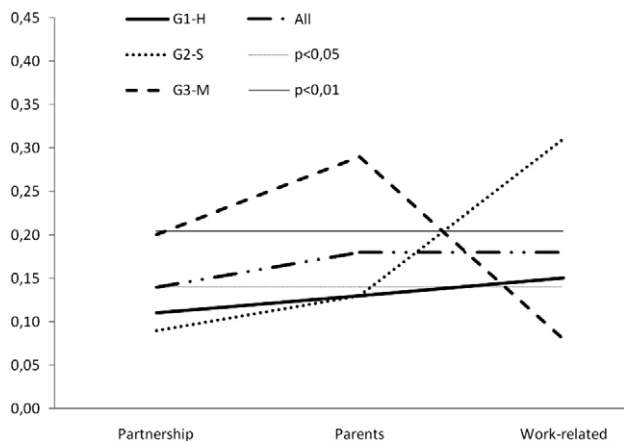


Fig. 2. Correlation coefficients between self-rated health and satisfaction with the most important interpersonal relationships.

associations were identified between SRH and mental and physical health, a moderate association between SRH and quality of life in groups G1-H and G3-M. There was also a moderate positive association between SRH and financial situation in group G3-M.

Strong positive associations between SRH and satisfaction with all three types of interpersonal relationship were found in all the soldiers' responses. The weakest such associations were identified in group G1-H, while there was a strong positive association between SRH and satisfaction with interpersonal relations at work for group G2-S, and a moderate positive association between SRH, satisfaction with partnership and satisfaction with parental relationship in the soldiers on missions (G3-M).

The SRH of all the participants was found to be in strong negative association with the escape/avoidance coping strategy. In group G1-H, SRH was not associated with any particular coping styles, while in group G2-S a

negative association between SRH and the escape/avoidance strategy was found. In the group of soldiers on missions (G3-M), SRH was negatively associated with seeking social support and accepting responsibility as coping mechanisms.

Discussion

The present study focused on the characteristics of SRH, and its associations with coping strategies and absence of work due to illness for the defined period of time was the key issue of our interest in three groups of professional Slovenian soldiers. Our sample of professional soldiers was representative with regards to gender (most of the participants were men) and educational level.

The G3-M group was statistically significantly younger than the others (28.4 years). However, the average age of the oldest group (G2-S) was still only 32.1 years. These determinants were in favour of a high SRH as the participants were young adults, in employment and in most cases with similar levels of education. In young people, transient medical conditions do not affect SRH; therefore, we did not expect to find significant differences in SRH which was indeed rated as high. The primary factors here are the young age of the subjects, and the basic good health that is a prerequisite for professional soldiers. However, those subjects who assessed their health as average or poor need special attention. SRH is generally lower in old age²² (although some studies report the opposite, due to the decreased expectations of health in older people¹¹).

The effect of gender on self-assessment cannot be evaluated properly from the data of this study because of the small sample of women, although no gender differences were found either between the groups or in the whole sample with regards to self-assessed mental and physical health (Table 1). There were also no statistically

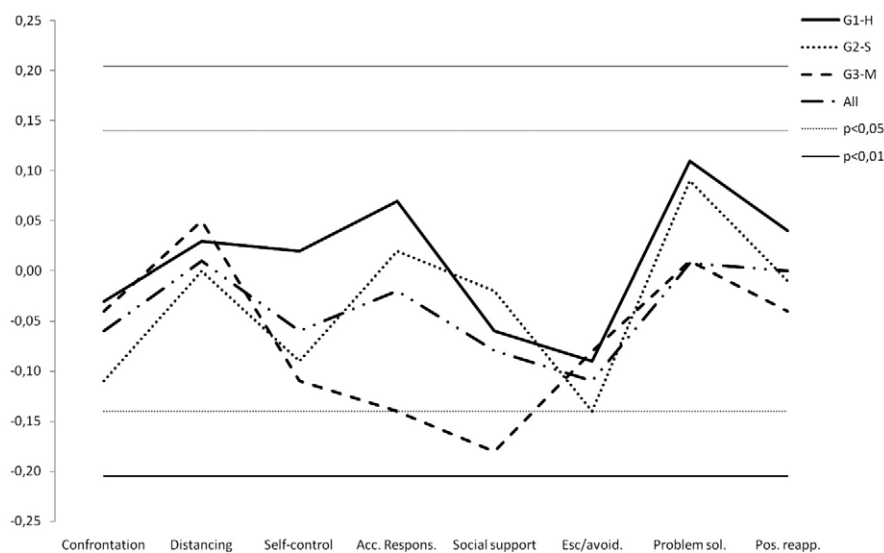


Fig. 3. Correlation coefficients between self-rated health and coping strategies.

significant gender differences between the groups in assessing their interpersonal relations (Table 2), or according to their chosen coping strategies (Table 3). Women rated their health lower than men, though with no statistical significance. This last finding approaches those of other studies which focused on SRH, e.g. Sujoldžić et al.¹⁷, which revealed consistent differences in gender in all health variables, women perceiving more health problems and reporting more somatic, depressive and anxiety symptoms.

SRH is also affected by socio-economic circumstances and education⁹. In general, people with a higher socio-economic status and a better education assess their health as higher⁸. In our survey, high positive associations were found between SRH and self-assessment of mental and physical health and overall quality of life, and a moderate positive one with financial situation (Figure 1). An association between lower educational status, higher scores of anxiety and depression and lower perceived quality of life has also been identified in Slovenian General Practice attendees²³.

It has already been confirmed by research that people who make poor lifestyle choices (excessive alcohol intake, smoking) have low SRH. The impact of healthy lifestyle attitudes is of particular importance in health self-assessment. People with such attitudes put more effort into achieving better health and having more control over their health. In 2005, Pan et al. reported lower SRH in current smokers compared to non-smokers²². We found less drinking of alcohol in our sample than in the general Slovenian population (4.8% versus 10%)²⁴ and more smoking than in the general Slovenian population (34.4% versus 22.8%)²⁵. The highest percentage of smokers was identified in G3-M – at 41.4%, almost twice that of the general population. We therefore note that some favourable and some unfavourable lifestyle factors were identified which affect self-assessment.

In general, the self-assessment of health is more likely to be lowered by chronic diseases than by acute ones⁸. Low self-assessment of health and incapacity are closely connected with serious diseases (e.g. epilepsy, cancer, diabetes) rather than with minor health conditions (e.g., eczema, hay fever). In our survey, we dealt with persons with few serious health issues, so a high SRH could therefore be reasonably expected. In addition, lower self-assessment is also connected to severe psychological stress, psychological symptoms and emotional disorders. The most common psychosomatic symptoms that we found included chronic fatigue, sleep disturbances, palpitations, back pain, stomach pain, headache, and diarrhoea. These symptoms probably influenced the lower than expected self-assessment of health in young, healthy, selected professional soldiers. Vulnerability to stress and an individual's capacity for resilience and/or recovery is complex, reflecting his or her biological state and genetic and environmental risk or resilience factors. The groups in our survey differed only in their use of the distancing strategy; it was used most often in the group G3-M (missions) and least in the group G1-H (Table 3).

The SRH of all participants was found to be in a strong negative association with the escape/avoidance coping strategy. In group G1-H, the SRH of soldiers was not associated with any particular coping styles, while in group G2-S a negative correlation between SRH and the escape/avoidance strategy was found. In the group of soldiers on missions (G3-M), SRH was in negative correlation with seeking social support and accepting responsibility (Figure 3). The impact of stress on the onset and course of the self assessment of one's health requires further research.

The variety and combination of health problems that we found point to the role of stress and stress related responses in individual soldiers. Comparing the three groups of soldiers, higher stress in the group of soldiers who were very healthy but exposed to special working conditions on missions (G3-M) was expected. More stress was also expected in the group of sick soldiers, who were also slightly older than other two groups (G2-S), where at least some of the problems could be attributed to the stress response. The physical and psychological impact of stress and the subsequent response of an individual who fails to adapt to or demonstrate resilience toward a particular stressor has been a focus of interest in the Slovenian army¹⁷, although not many differences in coping mechanisms between G1-H, G2-S and G3-M were found (Table 3). If the stress results from a failure to adapt to stressors, it may be a factor in causing disease. Preclinical studies have indicated that stress can cause long-term changes in multiple neuro-chemical systems²⁶. Stressful life events, a lack of social support, and depression are all thought to influence the risk factor levels for health status²⁷. Stressful life events at work have been found to be associated with feelings of depression and mental strain²⁸.

The subjects in our study tended to be mostly attached to their parents (Table 2). It is important to emphasize that the critical dimension of attachment is less about actual events and more about one's perception of those events. Our results may be interpreted as a lack of independence and personal maturity in the participants. Strong positive associations between SRH and satisfaction with all three types of interpersonal relationship were found among all the soldiers. The weakest of such associations could be observed in group G1-H, while a strong positive association was found between SRH and satisfaction with relationships at work in group G2-S, and a moderate positive association with partnerships and parental relationships among the soldiers on missions, G3-M (Figure 2). In addition, lower responses for work-related relationships might be explained as an independent stressor or as a lack of social support needed at work.

It is known from other studies that self rated health is higher in younger people, and they are also expected to be more resilient. Resilience is the capacity to recover following stress. From a genetic perspective, resilience is defined as the quality which prevents individuals who are at genetic risk for mal-adaptation and psychopatho-

logy from being affected by these problems. The subjects in G1-H seemed to be the most resilient, typically using systematic problem solving, and abandoning distancing as coping mechanism (Table 3). The subjects in G2-S reported the poorest physical health (Table 1) and a negative association between SRH and the escape/avoidance strategy was found (Figure 3). During the assessment period, more soldiers in group G2-S than in the other two groups assessed their wellbeing as bad or very bad. A strong positive association between SRH and satisfaction with relationships at work for group G2-S was identified (Figure 2). Therefore some leadership changes could be made to obtain better satisfaction with work-related interpersonal relationships, with a special emphasis on developing constructive coping skills mechanisms.

Commanding Officers or superiors should pay more attention to skills in interpersonal relationships, previous work experience and the development of protective coping strategies (non-competitive physical activities, hobbies). A key shift could be achieved by strengthening group cohesion and the quality of relationships in the units, and the implementation of a program to develop skills in interpersonal relationships and develop social support within the collective. No immediate gender-sensitive organizational changes appear to be needed since no gender related differences were identified. It may be assumed that in the Slovenian Armed Forces self-selected woman soldiers are recruited, who use more masculine coping mechanisms and are less focused on interpersonal relationships than their non-soldier peers.

Some limitations of the study should be mentioned. First, using component data from regular periodic reviews and patient records was not feasible, so self assessment as an indirect measure of health was used. The information obtained was appropriate for health status assessment in the previous year. A longer time period of health evaluation in the past proved unreliable. The second limitation is the response rate, which weakened the representativeness of our sample. The conclusions made

are more valid to privates than to non-commissioned officers and officers.

Conclusion

SRH is significantly associated with the quality of an individual's interpersonal relationships, and his or her socio-economic and psycho-physical condition in soldiers. Therefore, it could be used as an identifying tool for the most vulnerable subjects, who are prone to psychosomatic stress responses.

It seems that people who are assessing their health take into account a very wide range of important factors. Therefore self-assessment is based not only on the presence or absence of symptoms and a feeling of poor health, but also on the lifestyle that affects the risk of morbidity and mortality. The majority of high self-assessment in our study is due to the fact that the selected population was composed of young, physically healthy, and predominantly male soldiers. The number of subjects who assessed their health as poor or bad can be explained by certain psychological factors, psychological strain in relation to problems of a financial nature, inadequate work conditions, and unresolved housing problems, as self-assessment includes not only physical but also psycho-social well-being.

Although SRH needs to be studied further it represents a promising holistic approach in family medicine.

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SAMOPROCJENA ZDRAVLJA, ODNOS PREMA ŽIVOTNIM I PROBLEMIMA VEZANIMA NA ZDRAVLJE I STRATEGIJE SUOČAVANJA SA STRESOM KOD PRIPADNIKA PROFESIONALNIH SLOVENSКИH ORUŽANIH SNAGA

S A Ž E T A K

Cilj istraživanja bilo je ispitati odnos između samoprocjene zdravstvenog statusa (tj. psihološkog i interpersonalnog blagostanja, tjelesnog zdravlja, coping mehanizama) i odsutnosti s posla zbog bolesti u slovenskim oružanim snagama. U studiju bilo je uključenih 390 vojnika. Dvije grupe vojnika, zdrava (G1-H) i bolesna/manje zdrava (G2-S), stvorene su na bazi medijane ukupne odsutnosti zbog bolesti godišnje. Treća grupa sastojala se od vojnika na mirovnoj misiji u inostranstvu (G3-M). Upotrebjeni su upitnici za skupljanje demografskih podataka, životnih navika, popis životnih problema i popis zdravstvenih problema u posljednje tri godine, za samoprocjenu zdravlja i Folkman-Lazarus skala Načini suočavanja sa stresom. Samoprocjena fizičkog zdravlja bila je statistički značajno najbolja u grupi G1-H i najniža u G2-S. Razlike među polova nisu pronađene između grupa ili u cijelom uzorku. Najčešće coping strategije među svim vojnicima bile su rješavanje problema, pozitivno prevrednovanje situacije i samokontrola. Grupe su se razlikovale samo u korištenju strategije distanciranja. Kod samoprocjene zdravlja je za sve sudionike utvrđeno da je u jakoj negativnoj korelaciji sa coping strategijom bijega/izbjegavanja. U grupi G2-S više je vojnika ocijenilo svoje zdravlje kao loše; razlike između grupa bile statistički značajne. Jaka pozitivna korelacija između samoprocjene zdravlja i zadovoljstva s međuljudskim odnosima je utvrđena. Samoprocjena zdravlja kod vojnika pokazala se bitno povezana s kvalitetom međuljudskih odnosa i društveno-ekonomskim i psiho-fizičkom stanjem.