

Copyright is owned by the Author of the thesis. Permission is given for a copy to be downloaded by an individual for the purpose of research and private study only. The thesis may not be reproduced elsewhere without the permission of the Author.

**AN INVESTIGATION OF THE STABILITY OF THE SENSE OF
COHERENCE FOR THOSE ATTENDING A THREE - WEEK
REHABILITATION PROGRAMME**

A thesis in partial fulfilment of the requirements for the degree of

Masters of Arts

in

Rehabilitation

at Massey University, Palmerston North,

New Zealand.

Toni Jacqueline Hocquard

2005

TABLE OF CONTENTS

Table of Contents	i
Abstract	iii
Acknowledgements	iv
List of Appendices	vi
List of Tables	vii
Introduction	1
Disability, Chronic Illness and Health.....	2
The Sense of Coherence	4
Identification of the Research Question	6
Purpose of the Research	8
Literature Review.....	9
Relationship between the SOC, CI and Disability	10
Overview of Studies	11
SOC as a Stable Personality Trait.....	12
SOC as a State	15
The SOC as a Focus of Intervention.....	17
Summary and Conclusions	20
Research Questions, Hypothesis.....	22
Methodology	23
Methodological Approach	23
Methods.....	24
The Intervention	24
Participants	25
Research Design	25
Consultation.....	26
Procedure	26
Dependant Measures.....	28
Sense of Coherence -29 (SOC-29)	28
Short-form-36 Health Survey (SF-36).....	28
Acceptance of Disability Scale, Modified (ADM).....	30
Analysis	31
Results.....	33
SOC-29	35

ADM.....	37
SF-36	38
Relationship Between the Sense of Coherence, Adjustment and Health Status....	38
Discussion	42
Post Hoc Analysis.....	43
Low, Medium and High SOC Scores	43
Limitations.....	46
Recommendations for Further Research	47
Conclusions	51
References	53
Appendix A SOC as a Stable Personality Trait	63
Key: Appendix A.....	68
Appendix B SOC as a State	69
Key: Appendix B.....	70
Appendix C SOC as a Focus of Intervention.....	71
Key: Appendix C.....	73
Appendix D Information Letter	74
Appendix E Demographic Questionnaire	78
Appendix F Consent Form.....	80
Appendix G Sense of Coherence-29 (SOC-29).....	81
Appendix H SF-36v2 Health Survey	86
Appendix I Acceptance of Disability Scale (MOD.)	89
Appendix J The Impact of SOC-29 Scores on Drop Out Rate	97
Appendix K The Impact of SOC-29 Scores T1 to T4.....	98
Appendix L Means and SDs of Published Studies Using the SOC Scale.....	99
Appendix M Means and SDs of Published Studies Using the ADM.....	100
Appendix N Means and Standard Deviations for SF-36 and US General Population Means	101
Appendix O Massey University Ethics Committee Approval	102
Appendix P Bay of Plenty Ethics Committee Approval.....	103
Appendix Q Kuini Riripeti Kaunihera Letter of Support.....	105
Appendix R Queen Elizabeth Hospital Community Trust Letter of Support.....	106

ABSTRACT

Those with chronic illnesses or disabilities face numerous obstacles and issues as they come to terms with and manage the realities of their situation. How well health care providers and funders understand this can determine the types and quality of services offered. Antonovsky (1993) has developed the Sense of Coherence (SOC) concept, which introduces a salutogenic (health promotion) model of health. This challenges the pathogenic model (origins of disease) that dominates health care. A relationship between the SOC and coping has been established in the literature. Currently, the SOC is widely viewed as a stable personality trait, but emerging evidence suggests that the SOC may be amenable to change. The purpose of the study was essentially to investigate the stability of the SOC in relation to an intervention over time. The study was conducted using a time series design (Pre-admission (T1), admission(T2), discharge (T3), 6-month follow up(T4)). A convenience sample of 120 participants (93 women, 27 men) was recruited for the study. The instruments used as dependant measures were the SOC-29, the Acceptance of Disability Scale ADM (modified) and the SF-36. Analysis of the SOC-29 revealed a significant change over time ($p = .05$), with the follow up analysis indicating that this change occurred following the intervention. This same finding was also true of the ADM scores ($p = 0.0005$). This was not sustained at 6-month follow up for either the SOC or the ADM. Analyses of the SF-36 scores showed a significant improvement from admission to the 6-month follow up on all scores except general health. Only 72 participants completed at the 6-month follow up and this reduced the power of the study to yield a statistically significant result. Furthermore, a post-hoc analysis revealed that over 93% of the participants had medium to high SOC scores at the beginning of the study and this may have impacted on the outcome. There were significant correlations between the scores on the SOC-29 and the ADM and all scales of the SF-36 except physical function. As the significant change in SOC-29 scores was not sustained at the six-month follow up it could suggest that the SOC is indeed a stable trait. However, there were other factors identified, related to the characteristics of the sample and to wider factors that could have had an impact on the outcome of this study. In particular it is possible that a 3-week programme is not long enough to effect a lasting change in the SOC and this raises questions about health care delivery for those who have chronic illness or disability.

ACKNOWLEDGEMENTS

I would like to thank my supervisor Professor Steve LaGrow, who challenged and teased out of me a piece of work that I would not have believed I was capable of. It was your support and encouragement during the post-graduate papers that enabled me to even attempt this thesis. During the tough times you reminded me of my passion for the topic, which helped me to keep going when I could have easily given up. I have particularly appreciated your expert guidance and willingness to be available at a distance and for putting up with me when I was being less than intelligent.

To my second supervisor Dr Kieren Faull, whose support and enthusiasm got me started in the first place, I would like to thank you for planting the seed and supporting me throughout. You said I could do it and I have. With Steve in Palmerston North, it was you I 'bugged' the most and who proofread my numerous re-writes.

This study would not have been possible without the support of QE Health. I would particularly like to thank Ben Smit the Chief Executive and The QE Health Community Trust (who supported the project financially). Special thanks go to Maureen Harker who loaded much of the data into the computer and performed other tasks when needed. To Francie Denton, Kerry Hutchings and Jenny McQueen who delivered and collected questionnaires, a big thank you I know at times it was an additional burden to your already busy days. And to all the staff at QE Health who encouraged me and showed interest in the study from the start.

I would also like to thank Deanna Hape who proofread the final draft, and to Janet Toni who helped me to format it all and who literally saved my sanity.

My sincere thanks go to all those who participated in this study. It was a huge commitment that lasted over six-months, and I appreciate the giving of your time.

Finally, I would like to thank my family. To my husband, Laurie, for your unwavering belief and pride in me, cups of tea and help during computer crises not to mention all of the other jobs you picked up, I cannot express my thanks enough. To my son Chris, who must think that I am permanently attached to a computer, thank you for your

understanding when Mum was stressed, I will support you when it is your turn. Lastly, thank you to all the family and friends who have supported, encouraged and loved me through this process, I could not have done it without you.

LIST OF APPENDICES

Appendix A SOC as a Stable Personality Trait	63
Appendix B SOC as a State	69
Appendix C SOC as a Focus of Intervention	71
Appendix D Information Letter	74
Appendix E Demographic Questionnaire	78
Appendix F Consent Form	80
Appendix G Sense of Coherence-29 (SOC-29)	81
Appendix H SF-36v2 Health Survey	86
Appendix I Acceptance of Disability Scale (MOD.)	89
Appendix J The Impact of SOC-29 Scores on Drop Out Rate	97
Appendix K The Impact of SOC-29 Scores T1 to T4.....	98
Appendix L Means and SDs of Published Studies Using the SOC Scale.....	99
Appendix M Means and SDs of Published Studies Using the ADM.....	100
Appendix N Means and Standard Deviations for SF-36 and US General Population Means.....	101
Appendix O Massey University Ethics Committee Approval	102
Appendix P Bay of Plenty Ethics Committee Approval.....	103
Appendix Q Kuini Riripeti Kaunihera Letter of Support.....	105
Appendix R Queen Elizabeth Hospital Community Trust Letter of Support	106

LIST OF TABLES

Table 1. Data Collection Times	28
Table 2. Meaning of Scores	30
Table 3. Demographic Data	34
Table 4. Means and SDs for SOC-29 over time	35
Table 5. Mean and SDs of the Subscales of the SOC-29 Over Time	36
Table 6. Means and SDs for ADM over time	37
Table 7. Means and Standard Deviations for SF-36	38
Table 8. Correlations between the SOC-29, the ADM and SF-36 (T2, n=112)	39
Table 9. Shared variance (%) between the SOC-29 and the ADM and the SOC-29 and the SF-36.....	40