

RESEARCH ARTICLE

A mixed-methods exploration of psychological challenges and sense of coherence in individuals with chronic illnesses

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Abstract

Background: Although a multidisciplinary approach is essential for addressing complex physical and mental health problems, it remains underutilized in managing chronic illness, mental health, and sense of coherence (SOC).

Objective: This study examines the psychological difficulties of individuals with chronic illnesses in Kosovo and explores the relationship between their SOC and coping capacity.

Methods: This study employed a mixed-methods design to capture both the scope and depth of the phenomena under investigation. The quantitative component included 799 participants, who completed a demographic questionnaire, the General Health Questionnaire (GHQ-28), and the SOC scale. The qualitative component consisted of semi-structured interviews with 32 participants living with chronic illnesses, focusing on their experiences of coping, meaning-making, and perceived resources.

Results: Participants with chronic illnesses reported significantly higher SOC scores compared to those without chronic conditions ($p=0.04$). At the same time, they exhibited significantly higher levels of psychological distress ($p=0.0001$), including somatization ($p=0.0001$), anxiety and insomnia ($p=0.0001$), social dysfunction ($p=0.0001$), and severe depression ($p=0.0001$). Qualitative findings provided explanatory depth, indicating that the higher SOC observed among chronically ill individuals was largely attributed to the spiritual or religious engagement and a strong sense of responsibility toward caring for family and future generations.

Conclusion: These findings highlight the complexity of SOC among individuals with chronic illnesses, where cultural, social, and religious factors may simultaneously sustain coherence and contribute to psychological burden.

Keywords: Sense of coherence; Psychological problems; Chronic non-infectious diseases; Spiritual activities

1. Introduction

Chronic illnesses are widely recognized not only for their lasting physiological impact but also for the significant psychological burden they impose. While the literature extensively documents the biological and functional consequences of chronic disease, studies exploring the psychological dimension, particularly through the lens of sense of coherence (SOC), remain relatively limited.^{1,2}

SOC, as conceptualized by Antonovsky,³ reflects a person's capacity to perceive life as comprehensible, manageable, and meaningful. It serves as a central construct in understanding psychological resilience, adaptation to illness, and long-term health outcomes. A stronger SOC has been associated with reduced psychological distress, improved quality of life, and better coping with chronic illness.^{4,5}

Previous research has demonstrated that SOC influences not only how patients interpret and respond to their illness, but also how they maintain mental well-being.⁶ Moreover, several studies indicate that spirituality and religious coping may reinforce SOC in individuals facing long-term illness,^{7,8} offering protective effects against anxiety, depression, and emotional exhaustion.

Studies suggest that SOC is closely related to psychological distress in individuals with chronic illnesses. Lower levels of SOC have been linked to higher levels of depression and anxiety, with anxiety showing a notable link to reduced health-related quality of life.⁹ Similar patterns have been observed among individuals presenting with more pronounced symptoms of depression and anxiety, who tend to have lower SOC scores.¹⁰

In Kosovo, the burden of chronic diseases presents a growing public health challenge. With a population of 1.59 million, an average monthly salary of €639, and an unemployment rate of 10.8 -10.9% (according to the 2024 report),¹¹ many individuals face socioeconomic conditions that may exacerbate both physical and psychological health issues. The prevalence of chronic conditions is particularly high: diabetes (16%), pulmonary diseases (45%), obesity (53%), and uncontrolled hypertension (28%).¹² Furthermore, studies show that 70% are physically inactive, and 85% have inadequate nutritional habits,¹² factors strongly linked to both the onset and progression of chronic illness.

In culturally and religiously rooted contexts such as Kosovo and the wider Balkan region, SOC may be strongly influenced by community values, intergenerational responsibility, and faith-based coping. Evidence from Central and Eastern Europe supports the protective role of social cohesion on mental health: a cohort study conducted

in the Czech Republic, Russia, and Poland found that, for each standard deviation decrease in social cohesion, the odds of developing depressive symptoms increased over three years.¹³ Moreover, research on post-conflict societies in the Western Balkans indicates that war and political instability significantly disrupted social cohesion and trust, resulting in elevated rates of depression and anxiety among affected populations.¹⁴

Despite this compelling evidence, empirical research specifically examining SOC and chronic illness within the Kosovar population remains scarce, underscoring the need for context-sensitive investigation.

The purpose of this study is to investigate the psychological difficulties experienced by individuals living with chronic illnesses in Kosovo, and the relationship between SOC and their coping capacity. By identifying specific psychological stressors and exploring the potential utility of SOC for individuals with chronic illness, this research aims to contribute to a more nuanced understanding of mental health resilience within this vulnerable population.

2. Methods

This study employed a convergent mixed-methods design, in which quantitative and qualitative data were collected in parallel and given equal analytical importance. The quantitative component assessed psychological difficulties and SOC, while the qualitative component explored lived experiences of coping and meaning-making. Integrating both approaches allowed for a more comprehensive understanding of the research objectives. Considering that issues related to chronic conditions, SOC, and psychological problems are not widely known and that explanations for these phenomena are limited, we decided to investigate using both methodologies to enrich and fill gaps in previous research in this field. We aimed to obtain precise figures on psychological problems and SOC in patients with chronic illnesses using quantitative methods, and to explore these issues in greater depth through qualitative methods. This combination allowed for triangulation of findings and provided a more nuanced interpretation of the phenomena under investigation.

2.1. Ethical considerations

All participants were fully informed about the study's purpose and objectives before participation, and written informed consent was obtained. They were assured that their participation was voluntary and that they could withdraw from the study at any time without any consequences. Anonymity and confidentiality were strictly maintained: no personal identifiers were collected, and

all data were stored in password-protected electronic files accessible only to the research team. Data analysis and reporting were conducted at the group level to prevent the identification of individuals. The procedures followed the ethical principles outlined in the Declaration of Helsinki.

2.2. Participants

A total of 799 respondents participated in the quantitative study (357 males and 442 females), while 32 (18 males and 14 females) participated in the qualitative study. Given that the population of Kosovo is around 1.5 million, the sample size is likely sufficient to yield reliable results. Based on standard calculations for a 95% confidence level and a 5% margin of error, a minimum of 385 respondents would have been required; our sample exceeds this threshold by two-fold. Participants for the quantitative study were recruited through face-to-face, community-based data collection across several municipalities in Kosovo. Data were collected in non-institutional settings, primarily in participants' homes. Chronic physical illness status was based on self-reported medical diagnoses previously established by treating physicians; no psychiatric or psychological diagnostic assessments were conducted as part of the study. All questionnaires were administered in person using paper-based forms.

For the qualitative part, the number of participants was determined according to the principle of information power, meaning that 32 interviews provided sufficient variation across gender and regional background, and adequate analytical depth to address the research objectives. Participants for the qualitative component were purposefully selected to include only adults diagnosed with non-infectious chronic illnesses. This approach was adopted to enable an in-depth exploration of SOC and coping experiences specifically within this population. Recruitment was community-based and included participants from different regions of Kosovo; hospitalized individuals were not included, and only individuals aged 18 and above were included in the study. Detailed characteristics of the sample are presented in [Table 1](#).

2.3. Instruments

A demographic questionnaire was used to collect relevant demographic data necessary for our research, including age, gender, education level, place of residence, health status, etc. Psychological distress was assessed using the General Health Questionnaire (GHQ-28).¹⁵ The GHQ-28 assesses psychological problems in general, with a specific focus on somatic symptoms, anxiety and insomnia, severe depression, and social dysfunction. It does not diagnose psychological problems but instead scans respondents' mental health status. The questionnaire can be completed

in five minutes and does not require special training for administration or scoring. The scoring of the GHQ-28 questionnaire is divided into four subscales. Items 1–7 measure somatic symptoms, items 8–14 assess anxiety and insomnia, items 15–21 measure social dysfunction, and items 22–28 assess severe depression. Higher scores indicate higher levels of psychological distress in the respective domains.¹⁵

Sense of coherence was assessed using the SOC-29 scale.¹⁶ This questionnaire consists of 29 items and was used to measure SOC in patients with chronic illnesses, along with its three components: comprehensibility (11 items), manageability (10 items), and meaningfulness (8 items). Each question has seven response options. Initially, reverse scoring was applied where necessary, followed by the calculation of the total SOC score and the component scores. The total SOC score ranges from 29 to 203 points, with higher scores indicating a stronger SOC.

The GHQ-28 has demonstrated good psychometric properties across diverse populations, with reported internal consistency coefficients ranging from acceptable to excellent.¹⁵ Similarly, the SOC scale has been widely used internationally and has shown robust reliability and construct validity in previous studies.¹⁶ However, no formal validation studies have been conducted in the Kosovar population, which should be taken into account when interpreting the findings.

For the qualitative research, we conducted semi-structured interviews. A semi-structured interview guide was developed by the research team to explore participants' experiences related to the three components of SOC, while allowing flexibility to probe individual narratives in greater depth. Data collection was conducted by investigators experienced in conducting qualitative interviews.

2.4. Procedure

Data collection for both the quantitative and qualitative components was conducted between April and June 2024. The questionnaires were distributed in person to respondents from different regions in Kosovo. On average, participants required 20 minutes to complete the questionnaire. The purpose and objectives of the research were explained to them. Although the questionnaires were not expected to provoke any emotional reactions, participants were encouraged to contact the researchers if they experienced any discomfort. Additional procedural details for the qualitative component are provided below.

Qualitative data were collected through semi-structured interviews guided by a predefined interview protocol. The interview guide was structured around the three components of SOC (comprehensibility, manageability,

Table 1. Demographic characteristics of the participants

Characteristics	Quantitative research sample (<i>n</i> = 799)	Qualitative research sample (<i>n</i> = 32)
Age (years), mean $\pm$ standard deviation	35.92 $\pm$ 14.88	45.87 $\pm$ 20.46
Sex		
Male	357 (44.7%)	18 (56.3%)
Female	442 (55.3%)	14 (43.7%)
Education		
Has not finished primary school	14 (1.8%)	12 (36.5%)
Primary school	72 (9.0%)	7 (21.9%)
High school	335 (41.9%)	5 (15.6%)
Bachelor's degree	286 (35.8%)	6 (18.8%)
MSc	76 (9.5%)	2 (6.2%)
PhD	16 (2.0%)	0 (0.0%)
Monthly income (€)		
0–100	16 (2.0%)	0 (0.0%)
101–200	7 (0.9%)	2 (6.3%)
201–300	44 (5.5%)	1 (3.1%)
301–500	147 (18.4%)	2 (6.2%)
501–700	154 (19.3%)	3 (9.4%)
701–800	112 (14.0%)	12 (37.5%)
801–1000	244 (30.5%)	12 (37.5%)
>1,000	75 (9.4%)	0 (0.0%)
Marital status		
Single	295 (36.9%)	13 (40.6%)
Engaged	100 (12.5%)	1 (3.1%)
Married	364 (45.6%)	17 (53.2%)
Widowed	22 (2.8%)	1 (3.1%)
Divorced	18 (2.3%)	0 (0.0%)
Presence of any disease		
No	449 (56.2%)	0 (0.0%)
Yes	350 (43.8%)	32 (100.0%)
Medical treatment		
No	492 (61.6%)	0 (0.0%)
Yes	307 (38.4%)	32 (100.0%)

Note: Data presented as *n* (%), unless stated otherwise.

and meaningfulness) and allowed participants to elaborate freely on their experiences. Interviews were conducted by trained researchers in quiet, private environments, were audio-recorded with consent, and lasted approximately

30 minutes. The same core questions were asked across all interviews, with minor wording adaptations when necessary to enhance clarity.

Data collection for the qualitative study was also conducted in Kosovo in 2024. Prior to the interviews, all potential participants were contacted to provide detailed explanations about the study and the interview process. Participation in the study was entirely voluntary, and individuals were reminded that they could take a break or withdraw at any time. Audio recordings were made only with the participant's consent. To build rapport, the first five minutes of each interview focused on neutral topics before moving on to the research-related questions. Data collection was guided by the principle of information power, with interviews continuing until sufficient variation and depth were achieved.

2.5. Statistical analysis

The statistical analyses for quantitative data were performed using IBM SPSS Statistics, version 21.0.¹⁷ To convey general statements about the data, descriptive analysis was used. Frequencies and percentages were employed for categorical variables, and means and standard deviations were utilized for continuous variables. The independent samples *t*-test, one-way analysis of variance, Tukey's post hoc test, and Pearson's correlation analysis were used to examine differences and associations among continuous variables. A *p*-value of <0.05 was considered statistically significant for all statistical tests.

For thematic data analysis, we used theoretical thematic analysis, following the guidelines of Braun and Clarke.¹⁸ We adhered to the six key steps of this analytical approach. Given the complexity of the topics, theoretical thematic analysis was deemed the most suitable analytical approach.

Each researcher independently analyzed one interview without collaborating to identify themes and compare their findings to detect any differences. In general, approximately 80% of theme-level agreement was observed during the initial independent coding, and discrepancies were resolved through discussion to reach consensus. Following this, the researchers worked together to refine the themes that best aligned with SOC and its three components. The theoretical thematic analysis focused on codes, themes, and interview excerpts that were directly and indirectly linked to SOC and its three components: comprehensibility, manageability, and meaningfulness.

The analysis process involved identifying themes related to SOC, then revisiting and reviewing codes, themes, and interview quotes multiple times. Researchers engaged in a back-and-forth writing process to ensure a solid connection between codes, categories, themes, and interview quotes.

3. Results

The results of this research are presented based on findings from two complementary methodologies: quantitative and qualitative. The first part presents the quantitative research results, followed by the qualitative research findings.

The total number of participants in the quantitative research was 799, of whom 357 were males, and 442 were females. Sociodemographic characteristics of the sample are presented in Table 1. All participants in the qualitative research had non-infectious chronic health conditions.

Those with chronic diseases had significantly higher scores than those without health conditions on manageability, meaningfulness, and the SOC total score ($p < 0.05$) (Table 2). Additionally, those without chronic diseases had significantly higher scores than those with chronic health conditions on GHQ-28 total points, depression, social dysfunction, anxiety and insomnia, and somatic symptoms score ($p < 0.05$) (Table 2).

Participants having regular medical treatments had significantly higher scores than those without medical treatment on the meaningfulness score ($p < 0.05$) (Table 3). In terms of the GHQ-28 questionnaire, those without

any medical treatment had significantly higher scores than those with regular medical treatment on somatic symptoms score, anxiety and insomnia, social dysfunction, depression, and total scores ($p < 0.05$) (Table 3).

There was no statistically significant difference among participants with varying durations since diagnosis on comprehensibility, manageability, meaningfulness, SOC total score, somatic symptoms score, social dysfunction, and depression scores ($p > 0.05$) (Table 4). However, statistically significant differences across time since diagnosis were observed for anxiety and insomnia ($F = 2.341$, $p = 0.031$) and for the GHQ-28 total score ($F = 2.190$, $p = 0.044$) (Table 4), while post-hoc Tukey tests did not reveal statistically significant pairwise differences.

Pearson correlation analysis revealed a statistically significant moderate negative association between SOC and psychological distress (GHQ-28 total score) ($r = -0.475$, $p < 0.0001$) among participants with chronic illnesses (Figure 1). Figure 2 illustrates the mean GHQ-28 total scores across different time intervals since diagnosis among individuals with chronic illnesses, showing variations in psychological distress over time.

Table 2. Sense of coherence and its components, and psychological problems among participants with and without chronic conditions

Components	Chronic condition	<i>n</i>	Mean	Standard deviation	Statistics
Comprehensibility	Yes	427	45.38	11.04	$t = 1.299$; $p = 0.194$
	No	372	44.37	10.71	
Manageability	Yes	427	44.93	8.98	$t = 2.569$; $p = 0.010$
	No	372	43.27	9.18	
Meaningfulness	Yes	427	38.67	7.96	$t = 3.888$; $p < 0.0001$
	No	372	36.44	8.23	
Sense of coherence total score	Yes	427	128.97	23.51	$t = 2.926$; $p = 0.004$
	No	372	124.09	23.59	
Somatic symptoms	Yes	427	13.44	3.76	$t = 11.229$; $p < 0.0001$
	No	372	16.57	4.13	
Anxiety and insomnia	Yes	427	14.15	4.47	$t = 7.410$; $p < 0.0001$
	No	372	16.54	4.65	
Social dysfunction	Yes	427	13.67	2.89	$t = 7.337$; $p < 0.0001$
	No	372	15.37	3.64	
Severe depression	Yes	427	9.99	3.81	$t = 4.580$; $p < 0.0001$
	No	372	11.39	4.86	
General Health Questionnaire-28 total score	Yes	427	51.25	11.49	$t = 9.568$; $p < 0.0001$
	No	372	59.88	13.99	

Table 3. Sense of coherence and psychological problems among participants with and without medical treatment

Components	Regular medical treatment	<i>n</i>	Mean	Standard deviation	Statistics
Comprehensibility	Yes	492	45.04	10.86	$t = 0.436; p = 0.663$
	No	307	44.70	10.95	
Manageability	Yes	492	44.38	8.99	$t = 0.882; p = 0.378$
	No	307	43.80	9.28	
Meaningfulness	Yes	492	38.17	8.03	$t = 2.382; p = 0.017$
	No	307	36.76	8.28	
Sense of coherence total score	Yes	492	127.59	23.65	$t = 1.360; p = 0.174$
	No	307	125.26	23.62	
Somatic symptoms	Yes	492	13.73	3.87	$t = 10.490; p < 0.0001$
	No	307	16.76	4.12	
Anxiety and insomnia	Yes	492	14.43	4.53	$t = 6.479; p < 0.0001$
	No	307	16.59	4.68	
Social dysfunction	Yes	492	13.81	2.97	$t = 7.208; p < 0.0001$
	No	307	15.52	3.68	
Severe depression	Yes	492	10.18	3.99	$t = 3.788; p < 0.0001$
	No	307	11.38	4.87	
General Health Questionnaire-28 total score	Yes	492	52.16	12.04	$t = 8.676; p < 0.0001$
	No	307	60.26	14.03	

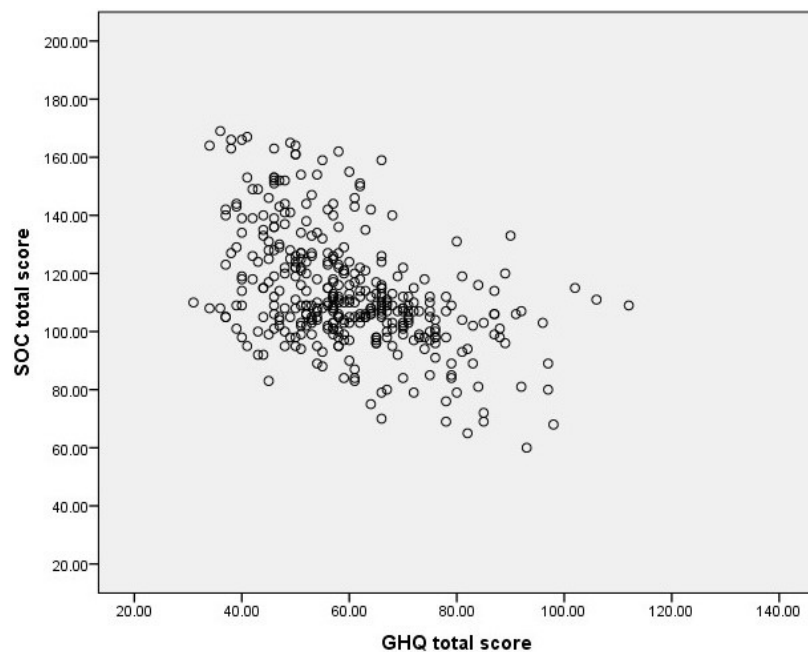


Figure 1. Relationship between sense of coherence (SOC) and psychological distress (General Health Questionnaire [GHQ]-28) among individuals with chronic illnesses

Table 4. Sense of coherence, psychological problems, and the time of diagnosis of the participants with disease ($n=350$)

Components	Time since diagnosis	<i>n</i>	Mean	Standard deviation	Statistics
Comprehensibility	Up to 1 year	85	44.59	10.65	$F = 0.625; p = 0.711$
	Up to 2 years	56	42.36	11.09	
	Up to 3 years	38	46.37	11.34	
	Up to 4 years	33	44.42	9.09	
	Up to 5 years	30	42.93	10.67	
	Up to 6 years	20	44.70	8.61	
	Up to 7 years	88	44.51	11.85	
Manageability	Up to 1 year	85	43.23	8.87	$F = 0.392; p = 0.884$
	Up to 2 years	56	44.52	8.70	
	Up to 3 years	38	43.03	10.10	
	Up to 4 years	33	41.73	8.83	
	Up to 5 years	30	42.87	11.41	
	Up to 6 years	20	44.65	7.92	
	Up to 7 years	88	43.43	9.90	
Meaningfulness	Up to 1 year	85	35.73	7.07	$F = 0.749; p = 0.610$
	Up to 2 years	56	36.25	7.48	
	Up to 3 years	38	37.89	8.50	
	Up to 4 years	33	36.61	8.73	
	Up to 5 years	30	37.67	10.20	
	Up to 6 years	20	38.35	7.73	
	Up to 7 years	88	35.54	9.25	
Sense of coherence total score	Up to 1 year	85	123.55	21.71	$F = 0.235; p = 0.965$
	Up to 2 years	56	123.12	22.53	
	Up to 3 years	38	127.29	25.53	
	Up to 4 years	33	122.76	22.11	
	Up to 5 years	30	123.47	28.41	
	Up to 6 years	20	127.70	20.96	
	Up to 7 years	88	123.49	26.73	
Somatic symptoms	Up to 1 year	85	16.50	4.07	$F = 1.153; p = 0.331$
	Up to 2 years	56	15.77	4.37	
	Up to 3 years	38	17.24	4.34	
	Up to 4 years	33	17.45	4.74	
	Up to 5 years	30	16.13	3.86	
	Up to 6 years	20	16.05	3.14	
	Up to 7 years	88	17.14	3.81	

(Cont' d...)

Table 4. (Continued)

Components	Time since diagnosis	<i>n</i>	Mean	Standard deviation	Statistics
Anxiety and insomnia	Up to 1 year	85	17.14	4.57	$F = 2.341; p = 0.031$
	Up to 2 years	56	16.05	4.38	
	Up to 3 years	38	17.87	4.76	
	Up to 4 years	33	17.76	5.44	
	Up to 5 years	30	14.83	5.18	
	Up to 6 years	20	14.95	3.25	
	Up to 7 years	88	16.40	4.43	
Social dysfunction	Up to 1 year	85	15.70	3.43	$F = 1.889; p = 0.082$
	Up to 2 years	56	14.80	3.27	
	Up to 3 years	38	16.18	3.98	
	Up to 4 years	33	15.45	4.17	
	Up to 5 years	30	14.20	3.44	
	Up to 6 years	20	14.10	2.69	
	Up to 7 years	88	15.87	3.84	
Severe depression	Up to 1 year	85	11.03	4.49	$F = 1.974; p = 0.069$
	Up to 2 years	56	10.55	4.79	
	Up to 3 years	38	12.21	5.55	
	Up to 4 years	33	13.27	6.39	
	Up to 5 years	30	11.40	5.47	
	Up to 6 years	20	9.35	2.62	
	Up to 7 years	88	11.62	4.45	
General Health Questionnaire-28 total score	Up to 1 year	85	60.39	13.20	$F = 2.190; p = 0.044$
	Up to 2 years	56	57.18	14.25	
	Up to 3 years	38	63.50	15.15	
	Up to 4 years	33	63.94	17.53	
	Up to 5 years	30	56.57	12.98	
	Up to 6 years	20	54.45	8.27	
	Up to 7 years	88	61.03	13.10	

In terms of comprehensibility, interviews with chronic illness patients emphasized that life is filled with uncertainties, including the unpredictability of their future. The interviewees noted that many aspects of life and plans remain unsettled, and for some, difficult to understand. Regardless of this uncertainty, they emphasized the importance of striving to achieve one's personal goals and objectives (Table 5).

A key finding from the interviews concerned relationships with people, particularly those who are close to them and relatives. The interviewees shared that they often feel they are not fully understood. They also

expressed significant disappointment stemming from the expectations they had about the people in their lives. Many invested significant emotional effort and expected similar reciprocity, only to encounter the opposite (Table 5).

Another theme is the lack of control over life and its direction. The interviewees noted that one's life is not only shaped by personal decisions but also by those of others in one's surroundings. This external influence makes life feel beyond their control or power. The interviewees also touched on the frustration of being unable to exert significant influence over the trajectory of their lives. This perceived lack of control led to considerable worry and

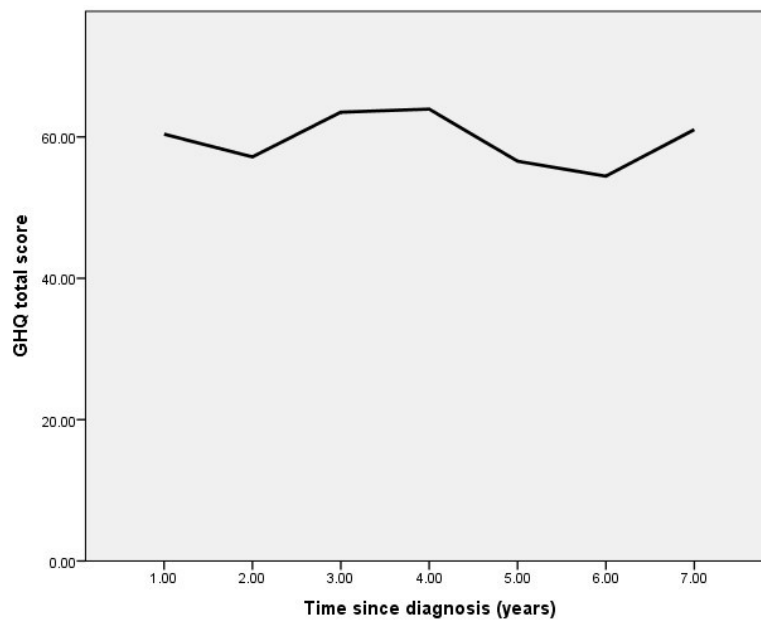


Figure 2. Changes in psychological distress (General Health Questionnaire [GHQ]-28) over time since diagnosis in individuals with chronic illnesses

Table 5. Comprehensibility among chronic patients

Themes	Interviews quotes
Timing	“There are some moments, and chances in life, and these are like a bell...if you are not in time when the bell rings, you will lose your chances and opportunities”
	“Sometimes we do not know what is good and bad, sometimes we can make a mistake, people can be successful in their life, like in professional life, but they may lose control of their family and children”
	“We always try for the best, but you never know, sometimes life brings you very close to the objectives, but you can never achieve”
	“I do not know what will happen in the future, it doesn't look logical to me to have a feeling that I will know what will come after me and around me in the future... Sometimes things do not go as you planned, sometimes things are out of control”
Unknown and uncertainty	“There are some things in our life that make sense, some don't, life is like this, you never know what is coming, or you know a little”
	“Since I was younger, I thought I knew people around me, but now I see that that is impossible, sometimes people are polite, sincere... on the other hand, these people cause you a damage”
	“I have the feeling that society does not understand me, but I am understandable for them, they feel free to talk about their problems with me, they believe that I can help them”
	“I have that feeling that I do not know people, I have been disappointed a couple of times, from the relatives and people that I was close to... I have experience of being surprised by people, for bad and good things, perhaps this is because I have been expecting too much from the people”
Uncontrol	“I am surprised by the people I thought I knew them...disappointment comes from the fact that we give people too much but we do not get something from them, it seems like we create an illusion for people, I think that disappointment comes from our high expectations for the people”
Without an impact	“There are difficulties to have everything under control... the life of the people doesn't depend on their choices and decisions, but also depends on the choices of their environment and the people around them”
	“It's normal that we can't change things in our lives... Sometimes you take things a bit closer to your heart, you don't distance yourself, and it's more painful, and preoccupies you, even though you can't change nothing”

preoccupation, even though they acknowledged that such circumstances appear unchangeable (Table 5).

The interviewees emphasized the importance of access to diverse resources for a fulfilling life. They pointed to family, social, educational, and financial resources as being crucial for a person's well-being. Notably, the lack of such resources, particularly the shortage of job opportunities, was identified as a key driver of migration among younger generations (Table 6).

Additionally, the interviewees observed that while having access to these resources can improve one's quality of life, it can also increase stress and worry. Managing these resources demands significant time and energy from individuals (Table 6).

The interview findings also underscored the responsibility people feel to build and secure resources for their children, grandchildren, and future generations.

Individuals perceived their role as extending beyond personal advancement to include creating a better world for future generations, which they viewed as one of their most important duties and obligations (Table 6).

The interviewees emphasized that their life plans and goals are complex and deeply intertwined with the opportunities available in their homeland and its broader developments, which they described as intricate. They noted that their plans are flexible and subject to change, often influenced by the circumstances and actions of others. Moreover, they linked their goals to family, work, education, relatives, and social relationships. While they considered their personal goals to be modest, their plans for family, children, and the community were seen as more significant. However, they acknowledged these goals as major life challenges that require continuous effort and perseverance (Table 7).

Table 6. Manageability among chronic patients

Themes	Interviews quotes
Money	"Long-term plans are purposes and plans that can cost, short-term plans are plans and purposes that don't cost"
	"Life is not just about money, but also about culture, well-being, respect for people, and humanity. These are some factors that have an impact and create the human being"
Resources impact	"Nowadays you have 100 more things around in your house, something that in the past you did not have. But having more things around requires you to spend time managing these things, and this can cost you more, like making you more stressed and increasing your preoccupation"
Creating resources for your descendants	"People create their own resources, step by step, but I think you can never be satisfied with this...you have to think to offer more for your children, nephews, and nieces"
Family, social, education, and financial resources	"I do not have too many friends, but those who are my friends are for a long time, and I am happy to have them. I am connected with them... as for financial resources, I work, I have a job, and I like it, this work makes me feel happy"
	"Lately, I do not need something more; I have my family and relatives. I feel accomplished, it is enough, I am the type of person that I do not welcome changes in my life, as per financial resources, I am not independent, but I believe I will be in the future"
	"I am preoccupied with the things around me because these may impact society, including the economic situation, especially nowadays that inflation is going high...education is passing out day after day... Unemployment is high, and this is the reason the younger generation is migrating"
	"I have invested a lot in my life, in education, training, but now I am disappointed I can't fulfill the needs of my family and myself"
Migration and lack of resources	"I have the family that accomplished me, I have friends and relatives, as per financial resources, I am not satisfied with this, because it is not the way I planned and dreamed"
	"Usually, the thing that is preoccupation me mostly is that our young generation does not have space for recreational activities, also they are studying but they do not get a job... this is something that is pushing our youngsters to make another solution, like migration"

As a result, they perceived their future as uncertain, with many unknowns regarding the direction life will take and what lies ahead. The interviewees accepted it as natural not to know their future, understanding that plans cannot always be precise. Instead, they draw strength from

their faith in God, whom they believe sets everything in its rightful place and determines each person's destiny. The interviewees also had potential plans for migration, but only if their efforts in their homeland prove unsuccessful (Table 7).

Table 7. Meaningfulness among chronic patients

Themes	Interviews quotes
The purpose of life and hope	"Our state is going through insecure phases of its future, people of my age try to have clear life purposes, but it depends on continuity"
	"Purposes and life plans can be changed every day; at the end of the day, I hope that I will not regret my choices"
	"Purposes in our life sometimes don't flow as you wish, but it depends on the others"
	"My biggest purpose in life is education and the advancement of my children"
Life as a challenge and religion	"You should try hard from the little things to things that are of wide interest, for example, society, family, country..."
	"Life is a challenge...it does not depend on you, but it depends on the challenges"
No plans	"Things in our lives are determined by God, but we should try our best"
	"We should thank God, and we should try to work, not neglecting, we should try to be really careful on our obligations and promises that we give to the people... these follow you for the rest of your life"
	"I do not want to know about my coming 10 years, it is like you drive a bicycle, if you focus on a point that is far from you, you will not see things that are close around you"
	"It happens many times that I do not know what to do, but when I am in this kind of situation, I say to myself, calm down, everything happens for the reason"
Plans to migrate	"I am confident about my future and my life, and if things go wrong, I will create new and achievable"
	"I try to plan the future, but there is no exact way and knowledge about the future and what is going to happen"
	"Our existence is confusing, related to the world and everything that surrounds us. As we grow up, there will be a question like Who am I? Whom do I want to become? What is around me?"
Professional, family, and personal development	"I tried to open a business, but I failed because of the monopoly and high taxes. I think I will open it somewhere else in another country very soon"
	"My future is far away from here, because until now I couldn't find myself here, and I am not rewarded for the work I have done here"
	"Our country doesn't give us the opportunity to achieve our dreams. I have clear plans about my future; achieving plans depends on me and my work, as well as the daily challenges"
	"I am looking for a job. I finished my master's degree, now I am looking for professional and personal development"
	"I have plans to find a job, to make my own family, to progress in my country, to support people in need, and to spend a good time with my family"

4. Discussion

This study aimed to explore the psychological challenges faced by individuals with chronic illnesses in Kosovo, with a particular focus on the relationship between SOC and coping abilities. By combining quantitative and qualitative methods, the findings indicate a nuanced interplay between chronic health conditions and psychological well-being, showing both areas of convergence and divergence between the two methodological strands.

Quantitative results showed that participants diagnosed with non-infectious chronic diseases demonstrated significantly higher levels of manageability and meaningfulness components, and overall SOC scores compared to those without such conditions. One possible explanation for these findings is that individuals diagnosed with chronic diseases may be more aware of the resources, such as medical professionals, medical treatment, lifestyle adjustments, and diet, needed (manageability) to cope with their illness. This awareness increased their understanding of their new role and the need for adaptive planning in response to their condition (meaningfulness). Consequently, this led to higher SOC scores in this group.

Similar findings have been reported previously, showing no statistically significant association between chronic inflammatory diseases and SOC.¹⁹ However, most previous studies reported that a stronger SOC is associated with better health outcomes.²⁰ Additionally, a weak SOC has been associated with an increased risk of developing diabetes of up to 46%.²¹

However, the findings of our research indicate that, despite having a higher level of SOC, patients with chronic illnesses exhibited higher levels of psychological problems, more pronounced symptoms of somatization, anxiety and insomnia, social dysfunction, and severe depression. In line with our findings, previous studies have also emphasized that chronic illnesses significantly reduce people's quality of life and are comorbid with psychological issues.^{22,23} Furthermore, chronic illnesses have been shown to be significantly associated with higher levels of psychological distress.²⁴

Here, triangulation of the quantitative and qualitative results is crucial. While our research showed higher levels of SOC among chronically ill patients, the interviews revealed that many of them experienced life as uncertain, difficult to comprehend, and beyond their control. This indicates that higher SOC scores may not necessarily reflect psychological protection, but rather the presence of cultural and social mechanisms, such as spirituality and responsibility for family, that sustain SOC while also increasing emotional burden.

In line with our findings, a significant inverse association between SOC and psychological problems has been reported previously.²⁵ However, unlike our research, the study focused on the general population rather than individuals with non-infectious chronic diseases.

Another finding emphasized that components such as comprehensibility and manageability showed a significant positive correlation and were the strongest predictors of psychological problems, whereas meaningfulness was not.²⁶

Nevertheless, many studies have found the opposite. A positive association between SOC, coping efficiency, and mental health has also been reported.⁶ Another study highlighted the direct and indirect effects of SOC on human well-being,⁷ as well as its mediating role in psychological functions.²⁷ Taken together, these findings suggest that the relationship between SOC and psychological outcomes may vary across populations and contexts.

We assume that the differences between our study and previous findings could be because individuals with chronic illnesses are primarily concerned about the physical problems they are experiencing. Additionally, they must adapt to and live with a chronic illness for the rest of their lives, considering the challenges that chronic diseases bring to their quality of life. All these factors are believed to contribute to the worsening of the psychological state of individuals with chronic illnesses.

However, the key point for discussion remains why SOC was higher in patients with non-infectious chronic diseases, while their psychological condition was worse. This is particularly interesting given that, both theoretically and based on various research findings, SOC is generally found to have a significant positive correlation with better psychological and physical health.

In our research, individuals without chronic illnesses exhibited significantly higher scores on various dimensions of psychological distress, including somatic symptoms, anxiety and insomnia, social dysfunction, and severe depression. Furthermore, those not undergoing regular medical treatment reported greater psychological burden than those under continuous medical care. These findings provide valuable insights into how SOC may function as an adaptive or sustaining mechanism in coping with chronic illness and highlight the mental health disparities influenced by health status and access to care. Moreover, it appears that not receiving medical treatment has increased the symptoms of the aforementioned psychological problems, potentially due to fear of the illness. Receiving therapy, to some extent, may have contributed to creating a sense of control over the chronic disease. Further research

in this field is needed, as no prior studies specifically address this topic.

Another finding of this study indicates that the duration since diagnosis did not significantly affect the SOC total score or its components. However, notable differences were observed in the levels of anxiety and insomnia scores based on the time since diagnosis. Specifically, anxiety and insomnia scores were highest during the first to the fourth years following diagnosis, declined in the fifth and sixth years, and rose again in the seventh year.

Psychological symptoms varied significantly over the years following diagnosis, with the highest levels reported in the fourth year and the lowest in the sixth.

Another finding regarding the relationship between treatment duration and SOC indicated no significant differences in SOC scores across treatment lengths. Nonetheless, individuals with no medical treatment reported significantly elevated levels of anxiety and insomnia, social dysfunction, and psychological distress in general, with the symptom severity peaking in the fourth year of therapy.

We were unable to find similar findings in previous research, suggesting a gap in current studies addressing the relationship between time since diagnosis, duration of therapy, SOC, and psychological distress.

The qualitative findings revealed that interviewees emphasized the comprehensibility component of the SOC, primarily through feelings of uncertainty and a lack of awareness of what might be important or valuable in life. Many described difficulties in achieving their life objectives, stating that this is due to life events often beyond their control and to the dilemmas and questions that arise along their life paths.

Interestingly, participants tended to normalize this perceived lack of control and unpredictability, viewing unexpected life events as part of the natural course of life. These themes emerged from discussions about the social sphere, life plans, and maintaining control over life. Overall, these insights suggest that people experience a low sense of comprehensibility in their lives.

Regarding the manageability component of SOC, the interview highlighted that important resources in life vary; they are not solely focused on money but also include social connections, family, and what individuals can provide for their children and loved ones. While financial resources were acknowledged as important, their value lay primarily in their capacity to invest in the well-being of future generations.

By taking on the responsibility for their descendants,

individuals experience a sense of resource scarcity, leading to migration plans to improve the situation for their families and future generations. Interestingly, participants emphasized that having sufficient or abundant resources can also be challenging, as they require more time for management and are more costly, ultimately leading to increased stress and concerns.

The manageability component of SOC was meaningfully shaped by the participants' sense of responsibility. Rather than perceiving a lack of personal resources, interviewees described themselves as responsible for generating and sustaining resources not only for their own well-being, but also for their families, descendants, and society as a whole. This reflects a collectivist understanding of responsibility and resourcefulness.

Regarding the third component, meaningfulness, the findings indicate that participants' life goals, plans, and personal and professional development were closely tied to their familial roles, social obligations, and a higher power, in this case, God's power and His will for things to happen.

Moreover, some participants expressed confidence in their plans, stating that even if they change, they will continue to adapt and adjust. This adaptive outlook reflects psychological flexibility and a sense of agency. At the same time, many participants perceived long-term planning as irrelevant, noting that life changes and various challenges can undermine such plans. For some, rigid long-term planning was even seen as a barrier to living in the present and appreciating day-to-day experiences.

Another key finding from the interviews is that migration was seen as a solution to problems and failures in life, especially when their home country does not provide adequate opportunities. This indicates that interviewees found meaning in their life experiences.

Despite significant challenges with comprehensibility, as reflected in participants' difficulties in making sense of their life experiences and daily realities, they still perceived their situations as manageable and meaningful.

These qualitative insights may help explain the quantitative finding that participants with chronic illnesses demonstrated higher levels of SOC. The component of caring for others and future generations, as well as spirituality and the typical Islamic religious perspective on daily struggles and life itself, served as protective factors. These factors help explain why SOC was higher among individuals with chronic illnesses.

The belief that life's problems and hardships are predestined by God and should be accepted as part of His will seems to foster resilience and meaning-making. This

religious worldview may thus contribute to maintaining a higher level of SOC among individuals living with chronic health conditions.

Other studies emphasize that a chronically ill patient's perspective on the past, present, and future plays a crucial role in shaping their sense of security—or, conversely, insecurity. Feelings of insecurity among individuals with chronic illnesses have been attributed to guilt related to illness, physical incapacity and weakness, fear of increasing dependence on others, loneliness, concerns about death, and mistrust in healthcare services.²⁸

In contrast, the findings of this study suggest that religious beliefs and spirituality can serve as significant protective factors. These insights are consistent with the existing literature, which demonstrates a strong correlation among SOC, spirituality, and religion. The mediating role of cultural and social variables in this relationship has been documented, and the relevance of these associations has been observed across different populations.^{7,29} Furthermore, a strong positive association between religiosity and SOC has been reported, particularly among middle-aged men and young and older women.^{8,30} The variability in findings across studies underscores the need for future research to examine the underlying dynamics of SOC and its components in populations with chronic illnesses.

This study has several limitations. First, the cross-sectional design prevents causal conclusions about the relationships between SOC components and psychological outcomes. Second, the self-reported nature of both quantitative and qualitative data may be subject to social desirability or recall bias. Third, while the qualitative data provided rich insights, the depth of exploration was constrained by time and resource limitations. Future studies employing longitudinal designs and larger, more diverse samples are recommended to validate and expand upon these findings. Additionally, the community-based nature of the sample and the lack of formal validation of the instruments in the Kosovar context may limit the generalizability of the findings. These factors should be considered when interpreting the results and addressed in future longitudinal and validation studies.

5. Conclusion

Overall, triangulating quantitative and qualitative findings in this study highlights the complexity of SOC in individuals with chronic illnesses. While patients reported higher SOC, they also experienced greater psychological problems, suggesting that SOC in this context reflects not only personal coping strategies but also cultural values, religious beliefs, and collective responsibilities. These

findings emphasize the need to interpret SOC not as a universal protective factor but as a construct shaped by local sociocultural conditions.

The findings of this study highlight the importance of integrating psychological care into the management of chronic illnesses, considering the elevated prevalence of psychological distress among this patient population. Health policymakers and institutions responsible for managing chronic physical conditions should prioritize providing psychological support to these patients. This may be effectively implemented through multidisciplinary care teams that address both physical and mental health needs, ensuring a holistic approach to patient well-being.

Additionally, the study recommends future longitudinal research to examine changes in SOC and its components (comprehensibility, manageability, and meaningfulness) over time in individuals with chronic illnesses. Such research would provide valuable insights into the evolution of SOC in these individuals, focusing on the factors that contribute to its increase or decline.

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Conflict of interest

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Conceptualization: All authors

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Ethics approval and consent to participate

The Dean's Council of the Faculty of Social and Psychological Sciences FSHSP Ethical Committee granted the ethical approval exemption. The study involved adult participants who voluntarily participated, used anonymous data, and did not include any medical intervention, experimental treatment, randomization, or manipulation. The study posed minimal to no risk to participants, and informed consent was obtained prior to participation. All procedures were conducted in accordance with the Declaration of Helsinki and relevant international ethical

standards.. All participants were fully informed about the study's purpose and objectives before participation, and written informed consent was obtained. They were assured that their participation was voluntary and that they could withdraw from the study at any time without any consequences. Anonymity and confidentiality were strictly maintained: no personal identifiers were collected, and all data were stored in password-protected electronic files accessible only to the research team. Data analysis and reporting were conducted at the group level to prevent individual identification.

Consent for publication

All participants gave a verbal permission to publish the data.

Availability of data

The original contributions presented in this study are included in the article. Further inquiries can be directed to the corresponding author.

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