

Low Pessimism Protects Against Stroke

The Health and Social Support (HeSSup) Prospective Cohort Study

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Background and Purpose—The association between optimism and pessimism and health outcomes has attracted increasing research interest. To date, the association between these psychological variables and risk of stroke remains unclear. We examined the relationship between pessimism and the 7-year incidence of stroke.

Methods—A random sample of 23 216 adults (9480 men, 13 796 women) aged 20 to 54 years completed the pessimism scale in 1998, that is, at study baseline. Fatal and first nonfatal stroke events during a mean follow-up of 7.0 years were documented by linkage to the national hospital discharge and mortality registers leading to 105 events.

Results—Unadjusted hazard ratio was 0.44 (95% CI, 0.25 to 0.77) for participants in the lowest quartile (a low pessimism level) when compared with those in the highest quartile (a high pessimism level). After serial adjustments for sociodemographic characteristics, cardiovascular biobehavioral risk factors, depression, general feeling of stressfulness, and ischemic heart disease, the fully adjusted hazard ratio was 0.52 (95% CI, 0.29 to 0.93).

Conclusions—In this population of adult men and women, low level of pessimism had a robust association with reduced incidence of stroke. (*Stroke*. 2010;41:187-190.)

Key Words: epidemiology ■ pessimism ■ psych & ■ behavior

There is a growing research interest in the relationship between dispositional optimism and pessimism, defined as a general tendency to exhibit positive and negative expectancies about the future, and health outcomes.¹⁻³ Although findings from well-conducted prospective studies suggest an association between optimism and pessimism as separate constructs and the risk of incident coronary heart disease (CHD) and cardiovascular disease mortality,^{1,4,5} no evidence to date is available of an association with the incidence of stroke. We used prospective data from a large sample of the Finnish population to examine the association between dispositional pessimism and the incidence of stroke.

Methods

Population

The Health and Social Support (HeSSup) study is a prospective cohort study on a population sample representative of the Finnish population of the following 4 age groups: 20 to 24, 30 to 34, 40 to 44, and 50 to 54 years at baseline in 1998; there was a total of 10 628 men and 15 267 women. The Turku University Central Hospital Ethics Committee approved the study.

Dispositional pessimism was assessed using the revised Life Orientation Test–Revised (LOT-R)^{6,7} (Cronbach's $\alpha=0.74$). The measure includes 6 statements, of which 3 are worded positively for optimism and 3 are worded negatively to indicate pessimism. We categorized pessimism mean scores into 4 groups based on the nearest approximate of the quartiles as in previous studies (Supplemental Table I, available online at <http://stroke.ahajournals.org>).⁴ The highest quartile (high pessimism) was the reference category in the analysis.

Follow-Up of Stroke Events

Linkage to the National Hospital Discharge Register and the Statistics Finland Mortality Register provided a virtually complete follow-up for hospitalizations and death for all participants who were treated in a hospital or died between January 1, 1999, and December 31, 2005. Stroke was determined by the International Classification of Diseases, 10th Edition codes I60 (subarachnoid hemorrhage), I61 (intracerebral hemorrhage), and I63 (cerebral infarction) as the main diagnosis of hospitalization or death.

Cardiovascular Risk Factors

History of hypertension, coronary heart disease, and diabetes mellitus at the time of the questionnaire in 1998 (ie, the survey year) was ascertained based on strict criteria.⁸ We excluded all participants hospitalized for CHD or cardiovascular disease and those with

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Table 1. Sample Characteristics as a Function of the No. of Stroke Events and Pessimism Score Levels

Baselin Covariates	No. Events/No. Participants	Quartiles of Pessimism Score				P Value for Trend
		1 (Lowest)	2	3	4 (Highest)	
Sex						0.243
Men	59/9480	3124 (33.0)	2333 (24.6)	2268 (23.9)	1755 (18.5)	
Women	46/13736	4467 (32.5)	3571 (26.0)	3319 (24.2)	2379 (17.3)	
Age group, years						0.001
20–24	3/6324	1938 (30.6)	1518 (24.0)	1664 (26.3)	1204 (19.0)	
30–34	8/5533	1937 (35.0)	1399 (25.3)	1273 (23.0)	924 (16.7)	
40–44	28/5555	1831 (33.0)	1473 (26.5)	1262 (22.7)	989 (17.8)	
50–54	66/5804	1885 (32.5)	1514 (26.1)	1388 (23.9)	1017 (17.5)	
Level of education						<0.001
Basic (compulsory)	44/7412	2136 (28.8)	1756 (23.7)	1911 (25.8)	1609 (21.7)	
Secondary	24/5232	1367 (26.1)	1273 (24.3)	1441 (27.5)	1151 (22.0)	
College	26/7400	2696 (36.4)	2033 (27.5)	1654 (22.4)	1017 (13.7)	
University	11/3172	1392 (43.9)	842 (26.5)	581 (18.3)	357 (11.3)	
Marital status						<0.001
Other	25/7674	2325 (30.3)	1735 (22.6)	1881 (24.5)	1733 (22.6)	
Married/cohabiting	80/15542	5266 (33.9)	4169 (26.8)	3706 (23.8)	2401 (15.4)	
Current smoker						<0.001
No	62/15508	5256 (33.9)	4114 (26.5)	3714 (23.9)	2424 (15.6)	
Yes	35/5862	1717 (29.3)	1311 (22.4)	1441 (24.6)	1393 (23.8)	
Missing	8/1846	618 (33.5)	479 (25.9)	432 (23.4)	317 (17.2)	
High alcohol intake (200 g of alcohol/week*)						<0.001
No	87/20956	6950 (33.2)	5412 (25.8)	5034 (24.0)	3560 (17.0)	
Yes	18/2260	641 (28.4)	492 (21.8)	553 (24.5)	574 (25.4)	
Obesity (body mass index \geq 30 kg/m ²)						<0.001
No	83/20992	6973 (33.2)	5395 (25.7)	5050 (24.1)	3574 (17.0)	
Yes	22/2224	618 (27.8)	509 (22.9)	537 (24.1)	560 (25.2)	
Sedentary lifestyle (<2 MET hours per day)						<0.001
No	69/17855	6072 (34.0)	4672 (26.2)	4205 (23.6)	2906 (16.3)	
Yes	36/5361	1519 (28.3)	1232 (23.0)	1382 (25.8)	1228 (22.9)	
Depression (Beck Depression Inventory score \geq 10)						<0.001
No	97/22159	7559 (34.1)	5833 (26.3)	5408 (24.4)	3359 (15.2)	
Yes	8/1057	32 (3.0)	71 (6.7)	179 (16.9)	775 (73.3)	
General feeling of stressfulness in daily life						0.715
Low	46/10497	3464 (33.0)	2604 (24.8)	2574 (24.5)	1855 (17.7)	
Intermediate	27/5547	1790 (32.3)	1426 (25.7)	1312 (23.7)	1019 (18.4)	
High	31/7020	2294 (32.7)	1833 (26.1)	1666 (23.7)	1227 (17.5)	
Missing	1/152	43 (28.3)	41 (27.0)	35 (23.0)	33 (21.7)	
Hypertension or diabetes						<0.001
No	85/22136	7299 (33.0)	5648 (25.5)	5300 (23.9)	3889 (17.6)	
Yes	20/1080	292 (27.0)	256 (23.7)	287 (26.6)	245 (22.7)	
Ischemic heart disease						0.002
No	102/23016	7566 (32.7)	5864 (25.5)	5533 (24.0)	4083 (17.7)	
Yes	3/200	55 (27.5)	40 (20.0)	54 (27.0)	51 (25.5)	

*A total of 200 g of alcohol represent 16 drinks per week.

MET indicates metabolic equivalent task.

medication for CHD during or before 1998. Incident CHD events (International Classification of Diseases, 10th Edition codes I20 to I25) that occurred during the follow-up were used as a covariate in the analysis. Behavior-related risk factors include current smoking status, alcohol consumption, physical activity, and obesity. Depressive symptoms were assessed using the Beck Depression Inventory

(score <10 versus 10+). The general feeling of stressfulness in daily life was measured using the Reeder Stress Inventory.⁹

Statistical Analysis

We examined the relationship between pessimism and subsequent stroke events using 7 serially adjusted Cox regression models. We

Table 2. Hazard Ratios (95% CIs) for the Association Between Quartiles of Pessimism Score and Incident Stroke Events

Adjustments	Quartiles of Pessimism Score			
	1 (Lowest; 22 Events/n=7588)	2 (27/5904)	3 (29/5587)	4 (Highest; 27/4127)
Model 1: none	0.44 (0.25–0.77)†	0.69 (0.41–1.18)	0.79 (0.46–1.34)	1
Model 2: sex, age, education, marital status	0.47 (0.26–0.84)†	0.71 (0.42–1.23)	0.82 (0.48–1.39)	1
Model 3: sex, age, education, marital status+behavior-related risk factors	0.51 (0.25–0.91)*	0.79 (0.46–1.36)	0.89 (0.52–1.49)	1
Model 4: sex, age, education, marital status+hypertension, and diabetes	0.48 (0.27–0.86)†	0.73 (0.43–1.26)	0.83 (0.49–1.39)	1
Model 5: sex, age, education, marital status+depression	0.48 (0.26–0.87)†	0.73 (0.41–1.28)	0.83 (0.48–1.44)	1
Model 6: sex, age, education, marital status+general feeling of stressfulness	0.47 (0.270.84)†	0.72 (0.42–1.24)	0.82 (0.49–1.39)	1
Model 7: sex, age, education, marital status+incident CHD	0.44 (0.25–0.77)†	0.68 (0.40–1.16)	0.80 (0.47–1.36)	1
Model 8: all aforementioned	0.52 (0.29–0.93)*	0.80 (0.47–1.39)	0.88 (0.52–1.50)	1

* $P < 0.05$.

† $P < 0.01$.

Behavior-related risk factors are smoking, alcohol consumption, sedentary lifestyle, obesity.

combined men and women in the analyses ($P > 0.05$ for interaction with sex) and verified that the assumption of proportional hazards held (all $P > 0.05$).

Results

Data linkage to national health registers, on the basis of a written consent, was successful for 24 128 (93%) participants. A total of 23 216 participants had complete data on the pessimism scale and all covariates. Of them, 105 incident stroke events (fatal and nonfatal 25 subarachnoid hemorrhages, 23 intracerebral hemorrhages, and 57 cerebral infarctions) were documented during a mean follow-up of 7.0 years (range, 0.02 to 7.01 years; Table 1).

Table 2 presents the association of pessimism levels with incident stroke events. Compared with participants with a high level of pessimism (the highest quartile), those reporting a low level of pessimism (the lowest quartile) were at lower risk of stroke (hazard ratio=0.44, 95% CI=0.25 to 0.77). After serial adjustments, the fully adjusted hazard for stroke was 0.52 (95% CI=0.29 to 0.93) among those with low pessimism.

The survival curve for stroke among participants with the lowest quartile of pessimism differed significantly (log rank test, $P < 0.05$) from those in the other quartiles and the difference between the groups grew as a function of time (Figure).

Further analyses were run examining the role of optimism (in quartiles) in the risk of stroke. We found no evidence to suggest an association between optimism and the incidence of stroke ($P = 0.53$), lending support to the idea that pessimism and optimism are separate constructs. We also examined the association between pessimism and stroke incidence in analysis adjusted for optimism in addition to age, sex, education, and marital status. The adjustment did not alter the reduced incidence of stroke associated with low pessimism (hazard ratio=0.49, 95% CI=0.26 to 0.90).

Discussion

We examined the prospective association between dispositional pessimism and subsequent stroke events in a large population of men and women with no history of ischemic

heart disease or cardiovascular disease. We found that participants with a low pessimism level had a 48% lower risk for incident stroke over the 7 years of follow-up after controlling for many potential confounders. We found no evidence to suggest that the association was attributable to depressive symptoms, a correlate of both pessimism and the risk of stroke.^{10,11} It must be noted that we assessed depressive symptoms with the Beck Depression Inventory, which is a validated survey instrument but not a diagnostic tool for clinical depression.

The present study was based on a representative sample of the Finnish population in 4 age groups but did not include elderly participants, which may limit the generalizability of our findings. Our findings are broadly consistent with previous studies on the associations between pessimism and optimism and the risk of CHD or death.^{4,12} Our results highlight the importance of pessimism in particular for the incidence of stroke, even in analyses adjusted for optimism. In agreement with the present results, a recent clinical study showed a lower survival rate for pessimistic patients with

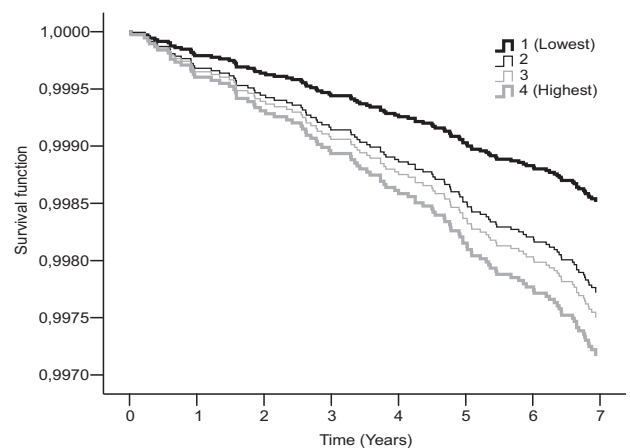


Figure. Cumulative incidence of stroke (fully adjusted*) by pessimism score quartiles. *Sex, age, education, marital status, smoking, alcohol consumption, sedentary lifestyle, obesity, hypertension and diabetes, depression, general feeling of stressfulness, and incident CHD.

cancer than their less pessimistic counterparts but no difference between individuals with high levels of optimism and those with low levels of optimism.¹³ The precise mechanisms underlying the link between pessimism and stroke remain unclear. Both behavioral (lifestyle behaviors) and biological (autonomic nervous system activity) mechanisms are plausible.^{5,10,11,14} Low pessimism may also be related to favorable trajectories of stroke risk factors over time. Further longitudinal studies are needed to examine these mechanisms in detail and whether interventions designed to reduce pessimism would alter stroke risk.

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Disclosures

None.

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