



The impact of loneliness and relationship quality on life satisfaction: A longitudinal dyadic analysis in persons with physical disabilities and their partners



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ABSTRACT

Objective: Persons with physical disabilities and their caregiving partners are at an increased risk of experiencing reduced life satisfaction. One potential explanation for this trend may be the potentially harmful effects of loneliness and poor relationship quality which this population often experience. To date, little is known about how the perceptions of loneliness and relationship quality affect life satisfaction in the disability and caregiving setting, furthermore the directionality of effect is not well understood. In this study, we investigate the actor and partner effects, and the reciprocal effects of loneliness and relationship quality on life satisfaction.

Methods: The analyses are based on longitudinal dyadic data from a Swiss community survey of persons with spinal cord injury (SCI) and their partners ($n = 246$). We employed mixed effects modelling to explore standardized (β) and unstandardized (B) actor and partner effects, and used cross-lagged path analysis to explore reciprocal effects.

Results: Loneliness was more prevalent in persons with SCI than in their caregiving partners. In caregiving partners, we found significant negative actor effects of loneliness ($\beta = -0.20$ ($-0.31, -0.10$)) and positive actor effects of relationship quality ($\beta = 0.15$ ($0.04, 0.26$)) on life satisfaction, and significant partner effects of relationship quality on wellbeing. In persons with SCI, only the negative actor effect of loneliness was significant ($\beta = -0.30$ ($-0.41, -0.18$)). Over time, loneliness demonstrated reciprocal associations with life satisfaction.

Conclusion: The findings of our study highlight the importance of reducing loneliness and strengthening relationship quality to improve life satisfaction in partnerships of persons coping with disability.

1. Introduction

Persons with physical disabilities and their caregiving partners are at greater risk from poor wellbeing than the general population [1–5]. One potential explanation for this trend may be the unfavorable experiences of loneliness and poor relationship quality which persons with disabilities and their caregiving partners face due to the limitations, strain and burden often associated with coping with disability [6–10]. Loneliness and relationship quality have both been identified as playing a crucial role in determining health and wellbeing [11–14]. The concept of loneliness is commonly defined as the subjective perception of social isolation [15]. Loneliness is, however, not synonymous with isolation, meaning that it may be experienced by individuals who are in long-term partnerships and embedded within social networks [15,16]. Persons coping with disability may become emotionally isolated from

their existing social circle, especially if they feel that they are no longer understood or accepted [6,17]. Relationship quality is a similarly subjective evaluation which assesses the depth, the purpose, and the availability of emotional support in partner relationships. Couples coping with disability may be at risk of poor relationship quality as the effort of caregiving becomes an implicit part of the relationship, meaning that the relationship is no longer balanced, roles within the relationship may change and the stress often associated with caregiving seeps into the intimate bond between partners [18,19].

To date little research has explored the associations between loneliness, relationship quality and life satisfaction in the disability context using longitudinal, dyadic data. While cross-sectional associations of loneliness and relationship quality with life satisfaction are robust in the general population, longitudinal research has identified that the nature of the relationship is often complex and bidirectional. Poorer life

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satisfaction has also been found to elicit perceptions of loneliness and low relationship quality, by causing individuals to withdraw from their social networks, and by instigating conflict within relationships [20–25]. Evidence from populations affected by chronic disease and disability has mainly focused on the positive association between relationship quality and life satisfaction, omitting other relevant constructs such as loneliness [26]. As we are not only interested in persons with disabilities, but also in their caregiving partners the availability of dyadic data is vital. Dyadic data not only enables the understanding how couples cope with disability, but also provides a comparison population, and enables the exploration of partner effects [27]. Evidence shows that relationships may be perceived differently by the actor and the partner, and that this may have differential effects on both the individuals' and their partners' life satisfaction [27–30].

Here we use spinal cord injury (SCI) as an informative case in point to investigate the impact of loneliness and relationship quality on life satisfaction in the context of physical disability, using longitudinal, dyadic data. SCI has a far-reaching impact on an individual's functioning, as affected persons sustain a complete or partial loss of sensory and motor function below the lesion level [31]. The functional limitations associated with SCI may have dramatic consequences on social participation and an individuals engagement in their social environment [32]. There is also evidence suggesting that assuming the role of caregiver to a person with SCI has a profound emotional impact on the individual and results in a change in relationship dynamics [33]. The aims are to 1) assess the actor and partner effects of loneliness and relationship quality on life satisfaction; and 2) evaluate the reciprocal effects of loneliness and relationship quality on life satisfaction in persons with SCI and their caregiving partners. We hypothesise that individuals who experience poor relationship quality and higher levels of loneliness are at greater risk of experiencing poor life satisfaction. Furthermore, we hypothesise that both the individuals' and the partners' experience of loneliness and relationship quality have an impact on individual life satisfaction, and that the association of loneliness and relationship quality with life satisfaction is reciprocal.

2. Methods

2.1. Sampling frame and participants

Participants for the pro-WELL study ('The social production of wellbeing in disability: a longitudinal study of persons with spinal cord injury and their caregivers') were recruited from the larger community survey of the Swiss Spinal Cord Injury Cohort Study (SwiSCI) [34]. The SwiSCI survey included persons with traumatic or non-traumatic SCI aged over 16 years living in Switzerland, and excluded persons with congenital conditions leading to SCI, new SCI in the context of palliative care, neurodegenerative disorders, and Guillain-Barré syndrome. Details of the study design, recruitment outcomes and participation rates of the SwiSCI survey are reported elsewhere [35,36]. The first wave of the SwiSCI community survey (September 2011–March 2013; $n = 1922$) served as the sampling frame for the pro-WELL recruitment. All persons aged 30–65 at the time of the pro-WELL recruitment and who spoke German or French were contacted simultaneously by mail in order to determine eligibility and willingness to participate ($n = 1108$). Those who were willing to participate and those who did not react to the written invitation were then contacted by telephone for further eligibility screening and to obtain consent for participation from both the person with SCI and their partner who was involved in informal caregiving. See [34] for details of the screening procedure. In total, 676 persons with SCI were eligible and 133 persons with SCI and their partners were recruited at baseline (total $n = 266$). A total of 123 couples ($n = 246$) completed at least two waves of data collection and were thus available for longitudinal analysis. Although the baseline response rate was restrained at 19.7% (refusal $n = 373$; no contact $n = 170$), a comprehensive non-response analysis demonstrated good

representation of the source population of persons with SCI with insignificant selection bias regarding sociodemographic and lesion characteristics [34].

2.2. Study design of pro-WELL

This paper uses data from pro-WELL, a longitudinal community-based survey with three measurement waves spaced over a 12 month period (t0: baseline; t1: month 6; t2: month 12). Data were collected using standardized telephone interviews and questionnaires (paper-pencil or online). Baseline data collection was effectuated between May and December 2015, and follow-up waves using a six month interval were then individually scheduled with reference to the previous data collection date. The study protocol was approved by the Ethical Committee of Northwest and Central Switzerland (document EKNZ 2014-285). We strictly observed all regulations concerning informed consent and data protection. A more detailed description of the study design is provided in the cohort profile of the pro-WELL study [34].

2.3. Measures

Loneliness was assessed using 3 items from the Revised UCLA loneliness scale which capture subjective feelings of loneliness, with a score ranging from 0 to 6, with high scores representing higher levels of loneliness [37]. This scale has recently been validated in an SCI population and showed adequate metric properties [38]. The Cronbach's alpha was 0.79, demonstrating satisfactory internal consistency in our sample.

Relationship quality was assessed using 8 items from the social support and depth subscales of the Quality of Relationship Inventory (QRI), assessing the meaningfulness and the positive role of the partnership, along with the extent to which one could turn to one's partner for support, and the responsibility or need one felt for their partner. The items were rated on a 4-point Likert scale, resulting in a sum score ranging from 0 to 24, with higher scores representing higher quality [39]. The Cronbach's alpha across all 8 items was 0.82, demonstrating satisfactory internal consistency in our sample.

Life satisfaction was assessed with the five-item Satisfaction with Life Scale (SWLS), designed to measure global cognitive judgments of satisfaction with one's life [40]. The SWLS has been used in previous SCI research [41]. The items were rated on a 5-point Likert scale ranging from "strongly disagree" (scored 0) to "strongly agree" (scored 4) [42]. A sum score ranging from 0 to 20 was calculated, with higher scores indicating higher wellbeing. The Cronbach's alpha across all 5 items was 0.83, demonstrating satisfactory internal consistency in our sample.

2.4. Potential confounders

To identify potential confounding variables, a preliminary analysis on associations between socio-demographics, socio-economic, loneliness, relationship quality and life satisfaction was performed. Financial hardship and stressful life events were the variables that were significantly related to the independent (loneliness, relationship quality) and the dependent variables (life satisfaction) and were thus included as confounders in multivariable models. Financial hardship was measured with a single item on participants ability to manage with their available financial resources. Response options included 'very scarce; scarce; just lasts; lasts good; lasts very good'. Stressful life events were assessed with a single item identifying whether the individual had suffered from a stressful event in the last 6 months. The variable was binary indicating individuals who had experienced a stressful event in the 12 months of data collection and those who had not. Age, sex, lesion characteristics (SCI only) and hours of caregiving (caregiving partners only) were also included in multivariable models due to evidence suggesting their confounding effects [16,43–45].

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