



Marital functioning, chronic pain, and psychological distress

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Abstract

This study examined whether marital functioning variables related uniquely to psychological distress and diagnoses of depressive disorder independent of pain severity and physical disability. Participants were 110 chronic musculoskeletal pain patients. Hierarchical regression results showed that marital variables (i.e. marital satisfaction, negative spouse responses to pain) contributed significantly to depressive and anxiety symptoms over and above the effects of pain severity and physical disability. In contrast, marital variables were not significantly related to diagnoses of depressive disorder (i.e. major depression, dysthymia, or both) after controlling for pain variables. In multivariate analyses, physical disability and marital satisfaction were uniquely related to depressive symptoms whereas physical disability, pain severity, and negative spouse responses to pain were uniquely related to anxiety symptoms. Only physical disability was uniquely related to major depression. The results suggest that models of psychological distress in chronic pain patients might be enhanced by attributing greater importance to interpersonal functioning and increasing attention to anxiety.

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1. Introduction

Marital discord and spouse responses to pain are positively related to pain intensity and physical disability (Ahern et al., 1985; Cano et al., 2000; Flor et al., 1987a,b; Kerns et al., 1990; Turk et al., 1992). Similarly, stressful marital interactions are associated with lower physical activity (Schwartz et al., 1994). Marital dissatisfaction, negative spouse responses, and poor family functioning are also associated with elevated depressive symptoms in pain clinic samples (Cano et al., 2000; Flor et al., 1987a,b; Kerns et al., 1990; Nicassio and Radojevic, 1993; Romano et al., 1997). Marital dissatisfaction might involve decreased intimacy and spousal support (Beach et al., 1990) whereas negative spouse responses may serve to punish social interaction with the spouse. Furthermore, marital dissatisfaction and negative spouse responses may contribute to

social withdrawal, hopelessness, and depression in some patients.

However, research on the association between marital variables and depression has not often accounted for the relationship between pain and depression. It is conceivable that marital variables are not significant correlates of depressive symptoms once the effects of pain variables are controlled. Based on research showing that spousal support is related to depressive symptoms after controlling for pain (Schiaffino and Revenson, 1995), we expect that marital satisfaction and negative spouse responses to pain will be significantly related to depressive symptoms above and beyond the effect of pain severity and physical disability. These pain variables were selected because research has consistently shown that they are related to depressive symptoms (Brown, 1990; Cano et al., 2000; Kerns et al., 1990; Schiaffino and Revenson, 1995). We hypothesize that a similar pattern of findings will emerge for depressive disorder diagnoses as assessed with a structured interview. It is important to examine diagnoses in addition to depressive symptoms because there are qualitative differences between

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the two (Coyne, 1994). Furthermore, medical chart reviews and symptom checklists are insufficient to make diagnoses because they often lack information about symptom severity or clinical significance (Banks and Kerns, 1996; Romano and Turner, 1985). The few studies that assessed major depression through structured interviews showed that chronic pain was associated with an increased likelihood of major depression (Ohayon and Schatzberg, 2003; see Bank and Kerns, 1996 and Romano and Turner, 1985 for reviews); however, no studies have examined the relative importance of marital functioning.

Depression shares some symptoms with anxiety (e.g. difficulty concentrating) so it is difficult to determine whether pain and marital variables are related to depression, anxiety, or both. This comorbidity issue is complicated by the use of depression scales that include anxiety symptoms (Clark and Watson, 1991). We expect that pain and marital variables will also be related to anxiety. Attention to the physical sensations of pain may result in worry (Aldrich et al., 2000) and attention to physiological symptoms of anxiety (e.g. racing heart, sweating). Marital satisfaction and spouse responses may also be related to physiological manifestations of anxiety because research has shown that stressful marital interactions are related to physiological arousal (Kiecolt-Glaser and Newton, 2001).

2. Methods

2.1. Participants

Patient participants ($N = 110$) were recruited from a midwestern university pain clinic specializing in spine problems. All patients were married and reported chronic (i.e. at least 6 month duration) musculoskeletal back pain ($n = 101, 91.8\%$) and/or neck pain ($n = 43, 39.1\%$) due to disc problems (e.g. herniated disc, degenerative disc disease), osteoarthritis, complications from surgery, and other problems. The vast majority of participants ($n = 81, 73.6\%$) also reported pain in other sites (e.g. arms, legs).

Fifty-six percent ($n = 62$) of the sample was female and 88.2% ($n = 97$) was Caucasian. Patient participants reported a mean age of 46.28 ($SD = 10.48$), mean marriage duration of 18.24 years ($SD = 12.12$), and mean education level of 14.04 years ($SD = 2.80$). On an average, they reported that their pain lasted 6.60 years ($SD = 6.10$). In terms of work status, 42.72% ($n = 47$) were working full- or part-time, 30% ($n = 33$) were receiving worker's compensation or social security disability benefits, 30.9% ($n = 34$) were unemployed, and 9% ($n = 10$) were retired. These percentages do not add up to 100% because some participants endorsed more than one employment status. There were no significant gender differences on demographic variables.

We compared our sample to other married patients in the multidisciplinary clinic from which they were recruited on

available demographic variables. There were no ethnic group or gender differences between the two samples. In addition, there were no significant differences on pain duration or education. However, our sample was significantly older than married patients from the clinic sample as a whole, $P < 0.01$. Specifically, the married patients in the entire clinic sample reported a mean age of 42.13 ($SD = 7.35$).

2.2. Measures

2.2.1. Marital adjustment test

The 15-item marital adjustment test (MAT; Locke and Wallace, 1959) is commonly used as a measure of marital satisfaction. Higher scores indicate greater satisfaction whereas lower scores indicate greater marital discord with 100 used as a cut-off score. The MAT has demonstrated good validity, inter-item reliability, and test–retest reliability (MacEwen and Barling, 1988; O'Leary, 1987; Smith et al., 1990). For the current sample, inter-item reliability was excellent ($\alpha = 0.91$). The mean marital satisfaction score for this sample was 108.52 ($SD = 28.56$), which falls within the range reported in other chronic pain studies (Cano et al., 2000; Flor et al., 1987a,b; Kerns et al., 1990).

2.2.2. Multidimensional pain inventory

The 52-item multidimensional pain inventory (MPI; Kerns et al., 1985) assesses a range of psychosocial variables that are associated with the chronic pain experience. The average of the four-item negative spouse responses to pain subscale is taken as an assessment of patients' perceptions of the spouses' responses to the patient when the latter is in pain. Only the negative spouse response subscale was used because research has shown a significant association between these responses and depressive symptoms but not between distracting or solicitous spouse responses and depressive symptoms (e.g. Cano et al., 2000; Kerns et al., 1990). Items included 'ignore you', 'express irritation at you', 'express frustration at you', and 'express anger at you'. The average of the three-item pain severity subscale is used to assess pain severity and intensity. All subscales of the MPI have adequate construct and discriminant validity, internal consistency, and test–retest reliability (Kerns and Jacob, 1992; Kerns et al., 1985). Kerns et al. (1985) reported alphas of 0.78 and 0.72 for negative spouse responses and pain severity, respectively. In the current study, inter-item reliabilities for both scales were excellent (negative spouse responses: $\alpha = 0.87$; pain severity: $\alpha = 0.86$). Participants reported an average of 1.70 ($SD = 1.55$) on the negative spouse responses subscale and mean pain severity was 3.85 ($SD = 1.17$), scores which are very similar to those found by Kerns et al. (1990).

2.2.3. Sickness impact profile

According to Kerns and Jacob (1992), the sickness impact profile (SIP; Bergner et al., 1981) is the most

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