

Research Article

Measuring Incompatibilities between Areas of Life in Cancer Survivors: Development and Psychometric Evaluation of the INCOMPAT-CS Instrument

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Received 18 October 2023; Revised 8 February 2024; Accepted 3 May 2024

Academic Editor: Ranjeet Singh Mahla

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Objective. Due to various long-term consequences of the disease, cancer survivors (CS) can experience incompatibilities between areas of life (work, family, household, leisure time, and disease) that can be associated with reduced satisfaction with these areas of life. To be able to assess such incompatibilities quantitatively, a six-item instrument (INCOMPAT-CS) was developed and psychometrically evaluated. **Methods.** Based on relevant theories, a multidisciplinary team developed the items of the INCOMPAT-CS. Descriptive analyses, exploratory and confirmatory factor analyses, as well as validity and reliability assessments were conducted using survey data from $n = 293$ CS collected as part of the CARES study. Incompatibilities between areas of life were measured with the newly developed INCOMPAT-CS instrument. **Results.** A one component solution with satisfactory model fit (normed $\chi^2 = 1.90$, RMSEA = 0.06, CFI = 0.99, and TLI = 0.97) was identified in exploratory and confirmatory factor analyses. The INCOMPAT-CS demonstrated acceptable internal consistency (Cronbach's $\alpha = 0.790$) and high test-retest reliability $\rho = 0.569$ ($p < 0.001$). Convergent validity could be demonstrated (CR = 0.858 and AVE = 0.506). Hypothesis-consistent correlations with role and social functioning measures further indicate convergent validity. **Conclusions.** The INCOMPAT-CS is useful to assess incompatibilities among areas of life in CS quantitatively. Moreover, it helps to reveal the areas negatively affected due to incompatibilities. This short instrument can be useful in aftercare or psychosocial support interventions to detect incompatibilities and work towards reducing them as a consequence to increase CS' wellbeing.

1. Introduction

Nearly 500,000 cancer cases are diagnosed for the first time annually in Germany [1]. The disease and its treatment can have long-lasting psychological, physical, and cognitive

effects. For instance, fatigue, which can be felt as physical, emotional, and mental exhaustion, is common in cancer survivors (CS) and can persist up to 15 years post diagnosis [2]. Moreover, psychological strain such as depression, anxiety, fear of progression, and other mental disorders can

affect CS [3–5]. Despite the various long-term effects of the disease and its treatment, CS aim for normalcy when recovering [6, 7]. Returning to normalcy includes exercising their usual social roles for instance in their family, at work, with friends, and in their leisure time. This includes engaging in social activities and hobbies, running the household, taking on family responsibilities, and for those CS of working age, returning to work. However, the shift from the sick role back to former healthy roles is an ongoing process for CS that can be accompanied by impediments in role functioning (i.e., the ability of an individual to fulfill responsibilities in different life situations [8]). Studies demonstrated that restrictions in general health-related quality of life and functioning can persist for over 10 years in CS compared to cancer-free controls [9, 10]. Furthermore, male CS experience a significant loss in role and social functioning compared to a cancer-free population [11]. Also, qualitative findings reveal problems of CS to fulfill demands and expectations of roles in different areas of life during their recovery [6, 12, 13]. For example, female breast CS felt feelings of uncertainty and ambiguity when wishing to act their usual healthy roles again and experiencing ongoing symptoms at the same time [12]. In addition, lacking support and services during this phase of survivorship and societal expectations to resume roles as prior to their disease conflicted the women [12]. Because individuals hold multiple roles, conflicting expectations within a role or between roles can lead to role conflicts [14]. Such contradictory expectations and role conflicts can also be described as incompatibilities of areas of life. The qualitative grounded theory of incompatibilities between areas of life describes how the additional sick role in long-term breast CS interferes with meeting expectations and demands in other areas of life (e.g., work, family, leisure time, and household) [15]. To cope with incompatibilities between areas of life, the breast CS employed different strategies and prioritized individual areas of life as a consequence [15]. For instance, re-evaluating the areas of life as a coping strategy allowed the breast CS to prioritize specific areas over others. Often the areas health and work were devaluated and deprioritized. These prioritization processes can be burdensome for CS and be associated with reduced satisfaction with areas of life.

A number of instruments to measure role functioning in CS exist. For example, the generic SF-36 is used to measure health-related quality of life in CS and includes subscales for social functioning (2 items) and role limitations due to physical health (4 items) and due to emotional problems (3 items) [16]. The items refer to a four-week period and assess whether problems with work or other regular daily activities occurred as a result of the physical health or emotional state as well as the extent and prevalence of the health status interfering with social activities with family, friends, neighbors, or groups [16]. The EORTC-QLQ-C30, which measures the health-related quality of life in cancer patients, includes both a role and social functioning subscale with two items each [17]. The items have a reference time period of one week. The role functioning items assess the extent to which respondents were limited in performing their work or other daily activities and in pursuing hobbies or other leisure

time activities. The social functioning items cover the extent to which the physical condition or medical treatment interfered with the family life or social activities. A more specific item bank containing 10 items in the style of the EORTC-QLQ-C30 was developed to be used as a computer adaptive test to measure role functioning (EORTC RF-CAT) [8]. The Functional Assessment of Cancer Therapy-General (FACT-G) questionnaire consists of 27 items of which seven measure functional wellbeing with a recall period of one week [18]. However, some of these items refer to sleep quality or acceptance of the illness. The 12-item short form of the PROMIS Cancer Function Brief 3D Profile (PROMIS CF 3D) was validated in an outpatient cancer rehabilitation population [19]. It includes the 3-item subscale “social participation” with items assessing trouble doing all the regular leisure activities, work, and family activities the respondents want to do. The inventory of functional status-cancer (IFS-CA) comprises of 39 items measuring the extent to which female cancer patients continue their usual activities in household and family, social and community, personal care, and their occupation [20]. The respondents are asked to indicate the extent to which they resumed the respective activities in the past weeks compared to before the cancer diagnosis. The more specific Work Role Functioning Questionnaire 2.0 (WRFQ) was validated in a sample of working cancer patients [21]. However, it is limited to measure work-specific role functioning with 27 items belonging to the four dimensions work scheduling and output demands, physical demands, mental and social demands, and flexibility demands [21]. To conclude, existing instruments are often subscales in the context of larger questionnaires, refer to shorter recall periods, or focus on the impact of the respondents’ health status on social or role functioning. To the best of our knowledge, no instrument measuring incompatibilities between the areas of life family, work, leisure time, housekeeping, and managing cancer disease is currently available for CS. Therefore, a six-item instrument to measure incompatibilities between areas of life in CS (INCOMPAT-CS) was developed. The items cover the difficulty to cope with the demands of different areas of life and explore which areas were restricted in favor of others as compared to before the diagnosis. The present study informs about the development of the instrument and evaluates its psychometric properties.

2. Materials and Methods

2.1. Data Collection. The INCOMPAT-CS was included in a survey of CS as part of the CARES study (Cancer rehabilitation support by cancer counseling centers). The CARES study is a feasibility study for a counseling intervention for CS with a quasiexperimental prepost design and two sequential study groups [22]. One group receives the regular counseling offered by cancer counseling centers (control group), while the intervention group receives the newly developed counseling intervention. It was intended to include 20 cancer counseling centers each enrolling 40 participants (20 each for the intervention and control group), leading to a sample size of $N = 800$ cases. Participants

were recruited in 18 outpatient psychosocial cancer counseling centers throughout Germany. The inclusion criteria were an oncological disease, problems and/or counseling needs regarding the occupational situation (from training to retirement phase), age of majority, sufficient German language skills, no cognitive limitations that impede participation in surveys or interviews, and informed consent. The exclusion criteria were no oncological disease, no problems and/or counseling needs regarding the occupational situation, age of minority, insufficient German language skills, cognitive limitations that impede participation in surveys or interviews, and missing informed consent. The present study is based on $n=293$ enrolled participants of the control group. Participants in the control group were surveyed twice, first in the beginning of the counseling after the study enrolment (T0) and a second time three months after enrolment (T1). The first survey T0 was handed out in the cancer counseling centers, while the second survey T1 was sent to the participants via mail by the German Cancer Society. The filled in paper-and-pencil questionnaires were sent to the German Cancer Society for data processing. For the present analyses, data from T0 ($n=293$) and T1 ($n=262$, response rate 89%) were used. Data were collected between May and October 2022. The study was approved by the Ethics Committee of the Medical Faculty of the University of Bonn (061-22; 09.04.2022).

2.2. Measures. A multidisciplinary research group (sociologists, psychologists, psychotherapist, and communication scientist) developed the INCOMPAT-CS items. The items were derived from the qualitative theory of incompatibilities in the areas of life [15] against the theoretical background of Dahrendorf's role theory [14]. Therein, social roles are defined as "bundles of expectations related to the behavior of position holders in a given society" (own translation) [14]. Because individuals typically hold multiple roles, conflicts can arise due to conflicting expectations within or between roles [15]. In line with Dahrendorf's [14] concept, the qualitative grounded theory of the incompatibilities of areas of life [15] proposes that the additional sick role in CS is associated with difficulties in meeting expectations in other areas of life (e.g., more resources are needed for the disease management, while side and long-term effects can affect the CS). After being diagnosed, existing incompatibilities are reinforced or new ones may occur in CS' lives. To reduce incompatibilities, different strategies may be applied. These include enduring or accepting incompatibilities, sacrificing, seeking or accepting help, setting limits, and re-evaluating areas of life. Moreover, as a consequence, individual areas of life may be prioritized, increasingly at the expense of health and work. A total of six items were derived from the theory of incompatibilities in the areas of life [15] and Dahrendorf's role theory [14]. One item measures the difficulty to reconcile demands in different areas of life. Five items assess which areas of life CS restrict (e.g., have you restricted doing your work in favor of other areas of your life?). All items score on a scale from 1: not at all, 2: a little, 3: quite a bit to 4: very much. A sum score was calculated ranging from 6 to 24, with higher values indicating more incompatibilities. To

increase content validity and comprehensibility, the items were pretested in one cognitive think-aloud interview with a CS. Sociodemographic measures were part of the CS survey and are used to describe the following sample characteristics: age in years (calculated from year of birth), gender (female, male, and diverse), marital status (married, single, widowed, and divorced), children (yes and no), and current work status (recoded to full-time, part-time, occupational reintegration, reduced earning capacity pension, retired, homemaker, unemployed, student, full-time or part-time not specified, and other). Disease-related variables were also part of the survey: time since cancer diagnosis (calculated from year of diagnosis) and cancer recurrence (yes, no, and do not know). Moreover, the respondents' type of cancer diagnosis was provided by the cancer counseling centers that enrolled the participants. The survey also included the EORTC-QLQ-C30 subscales for role and social functioning with two items per subscale scoring on a scale from 1: not at all, 2: a little, 3: quite a bit, to 4: very much [17]. The relative scores of the subscales were calculated following the manual, with higher values indicating a higher level of functioning.

2.3. Data Analysis. Descriptive statistics of the sample as well as the items and score of the INCOMPAT-CS were calculated (e.g., mean, standard deviation, minimum, and maximum).

An exploratory factor analysis (EFA) was carried out to investigate the factor structure. Based on the theoretical background, a one-dimensional structure was expected. The suitability for EFA of each item and the set of items was evaluated using the measure of sampling adequacy (MSA; >0.5) and the Kaiser-Meyer-Olkin measure (KMO; >0.5 mediocre, >0.7 good, >0.8 great, >0.9 superb) [23]. A significant Bartlett's test of sphericity would indicate that correlations between items are sufficiently large for principal component analysis [23]. Principal component analysis was used and factors were extracted with Varimax rotation [23]. The number of extracted factors was guided by the Kaiser criterion (eigenvalues >1) and inspection of the scree plot [23]. At least three items should load on one factor [24] with factor loadings >0.4 considered significant [23]. Cross loadings <0.4 were considered acceptable [24].

A confirmatory factor analysis (CFA) was conducted applying the following model fit criteria and thresholds: normed χ^2 ($\chi^2/\text{df} \leq 2$ good, ≤ 5 acceptable), root mean square error of approximation (RMSEA <0.07) with comparative fit index (CFI ≥ 0.97), and Tucker-Lewis index (TLI ≥ 0.95) [24].

As indicators of convergent validity, the average variance extracted (AVE ≥ 0.5) and construct reliability (CR >0.6 acceptable, >0.7 good) were assessed [24]. Moreover, bivariate correlations with the EORTC-QLQ-C30 subscales role and social functioning were calculated to evaluate convergent validity. In the relative score of the role and social functioning scales, higher values indicate a higher level of functioning. Since higher values on the INCOMPAT-CS indicate more incompatibilities, a moderate negative correlation was expected (Pearson's $\rho >0.3$ and <0.5). Cronbach's α (>0.7 acceptable, good >0.8) was used as an

indicator of the instrument's reliability in terms of internal consistency [23]. Test-retest reliability was assessed by correlating the INCOMPAT-CS score (T0) with the second measurement score (T1). Finding a high correlation (Pearson's $\rho > 0.5$) between measurements would indicate test-retest reliability.

Missing data of INCOMPAT-CS items ranged between 0.0 and 3.4% at T0 and were deleted listwise leading to $n = 279$ cases included in the factor analyses. Cases with missing data on the INCOMPAT-CS T1 measurement ($n = 59$) and EORTC-QLQ-C30 role functioning ($n = 2$) were excluded from the correlation analysis. Data from T0 were used for all analyses and data from T1 solely for the test-retest reliability analysis. SPSS v29 (descriptive measures, exploratory factor and reliability as well as validity analyses) and AMOS v29 (confirmatory factor analysis) were used for data analysis.

3. Results

The sample characteristics are shown in Table 1. All information were self-reported by the participants, except for the types of cancer, which were provided by the cancer counseling centers. The most common types of cancer in the sample were breast (46.6%), colorectal/anus (6.1%), and skin/melanoma (4.3%). The participants were on average 50.4 years old with a mean time of 1.9 years since diagnosis when being surveyed. Almost 11% experienced recurrence of cancer. Approximately 77% identified as female, 23% as male, and 0.5% as diverse. About 48% were married and 32% single. Nearly 2/3 of the participants had at least one child.

Table 2 shows the final exploratory model and descriptive measures of the items. Means of the items varied from 2.018 to 3.190 with SDs from 0.798 to 1.169. The average total score of the INCOMPAT-CS was 15.330 in the present sample. Principal component analysis with orthogonal Varimax rotation was carried out on the six items of the INCOMPAT-CS. Sampling adequacy was confirmed by a good KMO value (KMO = 0.80) and MSA values exceeding >0.5 for all items (MSA ≥ 0.705). Sufficiently large correlations for principal component analysis were indicated by a highly significant Bartlett's test of sphericity ($\chi^2(15) = 517.223$, $p < 0.001$). Two components had eigenvalues >1 explaining 67.8% of the total variance. Based on theoretical assumptions and the scree plot, it was decided to extract one component explaining 50.6% of the total variance. All six items of the INCOMPAT-CS load significantly on the extracted component with loadings from 0.570 to 0.826.

The one component exploratory model was replicated in the CFA as shown in Figure 1. After allowing the error terms of items 4 and 6 as well as 5 and 6 to correlate, satisfactory fit indices can be reported as follows: normed $\chi^2 = 1.90$, RMSEA = 0.06, CFI = 0.99, and TLI = 0.97. Table 3 gives an overview of the model fit indices for the original and modified model.

Table 4 shows the indicators of reliability and validity. Both AVE (=0.506) and CR (=0.858) exceeded the defined thresholds, suggesting convergent validity. Internal consistency was acceptable with Cronbach's $\alpha = 0.790$. Moderate

bivariate significant negative correlations of the INCOMPAT-CS and EORTC-QLQ-C30 subscales were $\rho = -0.496$ for role functioning and $\rho = -0.488$ for social functioning (both $p < 0.001$), further indicating convergent validity. The high positive correlation of the two measurements of the INCOMPAT-CS ($\rho = 0.569$, $p < 0.001$) indicated test-retest reliability.

4. Discussion

The aim of the present study was to inform about the development of the INCOMPAT-CS instrument and evaluate its psychometric properties. The EFA revealed a one-dimensional structure of the INCOMPAT-CS which was confirmed in CFA. Further analyses suggested reliability, convergent validity, and test-retest reliability of the INCOMPAT-CS instrument in the present sample.

For the presented analyses, a large sample of CS of different types of cancer collected in outpatient German cancer counseling centers was used. However, it should be noted that the sample consisted mainly of female CS diagnosed with breast cancer and higher education. These characteristics represent the clientele of cancer counseling centers in Germany. It is known that men use psychosocial services like counselling centers less often than women [25–27]. Therefore, future research should investigate the performance of the INCOMPAT-CS instrument and its psychometric properties in other samples of CS (e.g., more males, different types of cancer, or other cultural contexts).

In CFA, satisfactory model fit was achieved after allowing two error terms to correlate (error term of item 6 with the error terms of items 4 and 5). Such modifications are common in factor analysis and allow to statistically consider the existing correlations of the items [28]. Nevertheless, an additional CFA was run without item 6 (see Supplementary Material S1) and satisfactory model fit was achieved. Based on theoretic assumptions, item 6 was retained but can be monitored in future analyses.

As studies have shown that experiencing incompatibilities between areas of life and related adjustment processes can be burdensome for CS, the presented short and feasible instrument can be used as a screening tool by healthcare providers to detect incompatibilities in aftercare and initiate psycho-oncological support. Moreover, the INCOMPAT-CS can be used in psycho-oncological support measures to work towards reducing incompatibilities and increase CS' wellbeing. Due to its practicability, it is possible to provide CS with the instrument so that they can reflect how they are coping with demands of daily life and whether incompatibilities change throughout their cancer journey. Intraindividual trajectories of incompatibilities could be measured both by healthcare providers and CS themselves. Furthermore, it would be interesting to investigate whether certain groups of CS (e.g., age, type of cancer, or gender) experience incompatibilities in different areas of life. Consequently, such knowledge could be used to tailor support offers to CS' needs.

TABLE 1: Sample characteristics.

	<i>N</i> (%)	<i>M</i> (SD)	Min-Max
Type of cancer [†]			
Breast (C50)	130 (46.6)		
Colorectal/anus (C17–C21)	17 (6.1)		
Skin/melanoma (C43, C44)	12 (4.3)		
Leukemia (C91–C96)	11 (3.9)		
Respiratory and intrathoracic organs (C30, C31, C33–C39)	10 (3.6)		
Uterus, cervix, endometrium (C53–C55)	10 (3.6)		
Non-Hodgkin lymphoma, multiple myeloma (C82–C90)	10 (3.6)		
Prostate (C61)	10 (3.6)		
Eyes, brain, central nervous system (C69–C72)	9 (3.2)		
Morbus Hodgkin (C81)	8 (2.9)		
Urinary organs (kidney, ureter, urethra) (C64–C68)	7 (2.5)		
Head and neck (C00–C14)	7 (2.5)		
Gynaecological tumors	7 (2.5)		
Lymphomas	7 (2.5)		
Ovary (C56)	6 (2.2)		
Testis (C62)	4 (1.4)		
Pancreas (C25)	3 (1.1)		
Gallbladder, bile tracts (C23, C24)	3 (1.1)		
Liver (C22)	3 (1.1)		
Stomach (C16)	3 (1.1)		
Penis, other (C60, C63)	2 (0.7)		
Mesothelioma/soft tissue tumors (C45–C49)	2 (0.7)		
Thyroid, endocrine glands (C73–C75)	2 (0.7)		
Vulva, vagina, etc. (C51, C52, C57, C58)	1 (0.4)		
Bones, articular cartilage (C40, C41)	1 (0.4)		
Several localizations (C97)	1 (0.4)		
Esophagus (C15)	1 (0.4)		
Other	11 (3.9)		
Missing	2 (0.7)		
Unknown	1 (0.4)		
Time since cancer diagnosis (in years)		1.9 (2.7)	0–20
Missing	1 (0.4)		
Cancer recurrence			
Yes	30 (10.8)		
No	214 (76.7)		
Do not know	21 (7.5)		
Missing	14 (5.0)		
Age (in years)		50.4 (10.2)	19–76
Missing	1 (0.4)		
Gender			
Female	214 (76.7)		
Male	63 (22.6)		
Diverse	1 (0.4)		
Missing	1 (0.4)		
Marital status			
Married	133 (47.7)		
Single	90 (32.3)		
Widowed	9 (3.2)		
Divorced	44 (15.8)		
Missing	3 (1.1)		
Children			
Yes	182 (65.2)		
No	94 (33.7)		
Missing	3 (1.1)		
Current work status			
Full-time	108 (38.7)		
Part-time	61 (21.9)		
Occupational reintegration	14 (5.0)		
Reduced earning capacity pension	9 (3.2)		
Homemaker	1 (0.4)		
Unemployed	16 (5.7)		
Student	2 (0.7)		
Full-time or part-time not specified*	46 (16.5)		
Other	19 (6.8)		
Missing	3 (1.1)		

Notes. *n* = 279. *M*: mean; SD: standard deviation; Min: minimum; Max: maximum. [†]Data provided by cancer counseling centers (multiple choice). *These respondents indicated that they were on sick leave, in the “other” answer option. It is, therefore, assumed that these respondents are employed.

TABLE 2: Descriptive statistics and exploratory model of the INCOMPAT-CS.

Items of the INCOMPAT-CS	M (SD)	Min-Max	Skewness	Kurtosis	Factor loadings
(1) Since the cancer: how difficult is it for you to cope with the demands of different aspects of life?	3.190 (0.798)	1-4	-0.740	0.009	0.669
(2) Have you restricted your hobbies or other leisure activities in favor of other areas of your life?	2.756 (1.024)	1-4	-0.347	-1.003	0.774
(3) Have you restricted doing household activities in favor of other areas of your life?	2.455 (0.931)	1-4	-0.030	-0.868	0.826
(4) Have you restricted doing your work in favor of other areas of your life?	2.792 (1.169)	1-4	-0.391	-1.345	0.570
(5) Have you restricted your involvement in family life and carrying out family commitments in favor of other areas of your life?	2.118 (0.958)	1-4	0.305	-0.996	0.802
(6) Have you restricted the practice of health-related measures in favor of other areas of your life?	2.018 (0.969)	1-4	0.538	-0.784	0.583
Total	15.330 (4.111)	6-24			

Notes. n = 279. M: Mean; SD: standard deviation; Min: minimum; Max: maximum.

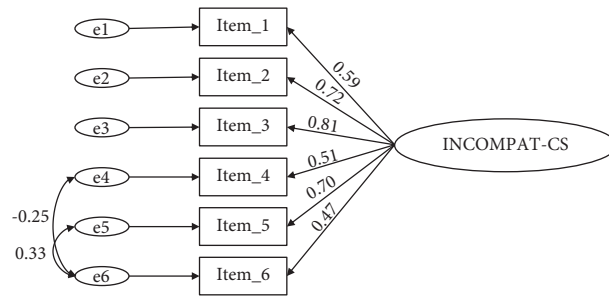


FIGURE 1: Modified confirmatory model of the INCOMPAT-CS.

TABLE 3: Model fit indices of the confirmatory models of the INCOMPAT-CS.

	Normed χ^2	RMSEA	CFI	TLI
Threshold	≤ 2 good, ≤ 5 acceptable	< 0.07	≥ 0.97	≥ 0.95
Original model	6.64	0.14	0.90	0.83
Modified model	1.90	0.06	0.99	0.97

Note. RMSEA: root mean square error of approximation, CFI: comparative fit index, TLI: Tucker-Lewis index. Values are highlighted in bold when threshold criteria are met.

TABLE 4: Reliability and validity measures of the INCOMPAT-CS.

Reliability and validity measures	
AVE	0.506
CR	0.858
Cronbach's α	0.790
Pearson's ρ with EORTC-QLQ-C30 subscale role functioning	-0.496***
Pearson's ρ with EORTC-QLQ-C30 subscale social functioning	-0.488***
Pearson's ρ with INCOMPAT-CS T1 measurement [†]	0.569***

Notes: $n = 279$. AVE: average variance extracted; CR: composite reliability. * $p < 0.10$; ** $p < 0.05$; *** $p < 0.001$. [†]Data from T1 were used in addition to T0 data to test test-retest reliability. Cases with missing data on the INCOMPAT-CS T1 measurement ($n = 59$) and EORTC-QLQ-C30 subscale role functioning ($n = 2$) were excluded from the correlation analysis.

In addition, due to the generic nature of instrument, the INCOMPAT-CS could be used in other patient groups (e.g., patients with a stroke). Future research could explore the adaptability of the instrument for other patient groups.

5. Conclusions

The INCOMPAT-CS seems to be a valid and reliable instrument to assess incompatibilities among areas of life in CS quantitatively. With this instrument, a measure with a focus on incompatibilities in the areas of family, work, leisure time, housekeeping, and managing cancer disease is available. Furthermore, it helps to reveal the areas negatively affected due to incompatibilities.

Data Availability

Research data are not shared.

Conflicts of Interest

Clara Breidenbach, Christoph Kowalski, Johannes Soff, and Sophie Schellack are employees of the German Cancer Society.

Authors' Contributions

Nicole Ernstmann and Christoph Kowalski supervised the CARES study. Clara Breidenbach und Christoph Kowalski collected the CARES data, and Kati Hiltrop performed the data analyses. The article was first drafted by Kati Hiltrop. Kati Hiltrop, Clara Breidenbach, Marie Degenhardt, Paula Heidkamp, Lina Heier, Christoph Kowalski, Sophie Schellack, Johannes Soff, and Nicole Ernstmann discussed the results and critically revised the article for important intellectual content. All the authors have read and approved the final manuscript.

Acknowledgments

We would like to sincerely thank our participants for their commitment and time. Our thanks also go to our project partners for their support and the German Federal Pension Insurance for funding the CARES project German Federal Pension Insurance (Deutsche Rentenversicherung Bund), Grant/Award number: 8011-106-31/31.128.1. Open access funding was enabled and organized by Projekt DEAL.

Supplementary Materials

Supplementary material S1: model fit indices of the confirmatory model of the INCOMPAT-CS without item 6. (*Supplementary Materials*)

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