Empirical research

Do attachment anxiety and hostility mediate the relationship between experiential avoidance and interpersonal problems in mental health carers?

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A B S T R A C T

Carers of people with mental illness frequently report interpersonal difficulties in their caring relationship, and experiential avoidance likely contributes to these problems. This study aimed to examine the relationship between experiential avoidance and eight interpersonal problem domains amongst lay mental health carers, and tested the mediating role of attachment anxiety and hostility. In addition, an alternative (reverse) mediation was tested in which experiential avoidance played the mediating role. A cross-sectional community-based sample of 145 mental health carers completed a questionnaire containing demographics and measures of interpersonal problems, experiential avoidance, attachment anxiety and hostility. Results indicated the relationship between experiential avoidance and interpersonal problems was fully mediated for the interpersonal problem domains of cold/distant and socially inhibited. Partial mediation was evident for the vindictive/self-centered, non-assertive, overly accommodating, self-sacrificing and intrusive/needy domains. No mediation occurred for the domineering/controlling domain. Alternative (reverse) model findings indicated partial/full mediation for the overly accommodating, domineering/controlling and vindictive/self-centered domains, and no mediation for the remaining five domains. Although tentative, findings suggest a mechanism for the relationship between experiential avoidance and particular domains of interpersonal problems that warrants further investigation. The importance of our data is highlighted by the burden and difficult relationships experienced by mental health carers, that requires targeted and effective psychological treatment.

1. Introduction

Mental health carers are individuals “who provides ongoing personal care, support and assistance to any other individual who needs it because that individual has a mental illness” (Carers Recognition Act, 2010, p. 4). The worldwide reduction in institutionalized care has seen caring responsibilities frequently fall to informal carers, with these parents, spouses, siblings, adult children, other relatives and friends providing substantial care (Johnson, 2000). The last decade has seen an increased focus on the complex interpersonal patterns that exist between carers and care receivers (Lawn & McMahon, 2014; Nelis, Clare, & Whitaker, 2012; Usher, Wong, & Perz, 2011; Wadham, Simpson, Rust, & Murray, 2016). Mental health carers frequently report interpersonal difficulties in relation to the person for whom they are caring (Acevedo Gallegos & Thompson, 2017; Spector, Charlesworth, Orrell, & Marston, 2016; Yesufu-Udechuku et al., 2015).

Interpersonal problems are difficulties encountered when interacting, or attempting to interact, with others (Horowitz, Rosenberg, & Bartholomew, 1993). Work in the field of interpersonal problems is often grounded in Interpersonal Theory which posits that a focus on interpersonal processes is needed to understand pathological behaviour (Horowitz et al., 2006; Leary, 2004; Sullivan, 1953). According to this theory, interpersonal processes exist along two principal dimensions: affiliation (ranging from cold behaviour to warm behaviour); and control (ranging from submissive behaviour to dominating behaviour) (Alden, Wiggins, & Pincus, 1990). The empirically established model of the interpersonal circumplex can represent these dispositions graphically (see Fig. 1). Control is represented as a vertical axis, affiliation as a horizontal axis, with interpersonal problems corresponding to combinations of these two dimensions (Alden et al., 1990; Horowitz et al., 2006). Eight domains of behaviour are defined, each describing a different interpersonal theme, namely: domineering/controlling, vindictive/self-centered, cold/distant, socially inhibited, non-assertive, overly accommodating, self-sacrificing and intrusive/needy.

The proportion of mental health carers experiencing interpersonal problems of significant difficulty has been found to be higher than that expected in the general population (17.7% vs 3-6%) (Quinlan, Deane, & Crowe, 2018a). Furthermore, mental health carers experience greater
rates of particular problem domains— with the Overly Accommodating and Self-Sacrificing domains the two highest (Quinlan et al., 2018a). There have been calls for more research on interpersonal problems in clinical and non-clinical groups, and more specifically the need to better understand associated cognitive processes (Gerhart, Baker, Hoerger, & Ronan, 2014). This call echoes a common criticism of work in the caregiving field; namely, a lack of data on underlying psychological processes (Devereux, Hastings, & Noone, 2009; Noone & Hastings, 2011).

Several theories of interpersonal problems point to the role of avoidance in contributing to, or perpetuating, dysfunction. Interpersonal theory posits that rigid attempts to avoid distress in social situations contribute to interpersonal problems (Holtforth, Bents, Mauler, & Grawe, 2006; pp. 486; Sullivan, 1953). Motivational approaches view interpersonal problems as a consequence of strong avoidance directed goals, which in turn lead to decreased satisfaction of a person’s approach directed goals (Holtforth et al., 2006; pp. 486; Holtforth, 2008). Attachment theory describes a number of dysfunctional attachment styles that may contribute to interpersonal problems; one of which is the avoidant style (Inge, 1992). It has been suggested that “experiential avoidance may provide a broad umbrella for conceptualising the avoidant functions of problematic interpersonal behaviours” (Gerhart et al., 2014, p. 292).

Experiential avoidance has been defined as a person’s tendency to be “unwilling to remain in contact with particular private experiences and take steps to alter the form or frequency of these events” (Hayes, Wilson, Gifford, Follette, & Strosahl, 1996, p. 1154). Experiential avoidance is associated with negative outcomes, such as: depression and anxiety (Hayes, Luoma, Bond, Masuda, & Lillis, 2006; Kashdan et al., 2014), poor physical health (Lillis, Levin, & Hayes, 2011), maladaptive coping strategies (Chawla & Ostafin, 2007) and dysfunctional cognitions (Crístea, Montgomery, Szamoksi, & David, 2013). Research within the broad carer field has indicated lay carers experience moderate to high levels of avoidance (Ulstein, Wyller, & Engedal, 2008), and these avoidance processes are associated with symptoms of anxiety (Cooper, Katona, Orrell, & Livingston, 2006), distress (Ulstein et al., 2008) and depression (Losada et al., 2015). Research specific to lay mental health carers has acknowledged the presence of avoidant behaviours (Kartalova-O’Doherty & Doherty, 2008; Mackay & Pakenham, 2012), however such studies have not included the broader experiential avoidance framework, which encompasses internal stimuli.

Experiential avoidance occurs when aversive internal experiences and the circumstances that trigger them are ignored or avoided (Hayes, Strosahl, & Wilson, 2012). In the context of mental health caregiving, there are many interpersonal circumstances where such aversive internal experiences may be triggered. Common internal experiences for lay mental health carers may include painful thoughts and difficult emotions such as guilt, shame, stigmatisation and social isolation. External stressors that characterise the role may include the care-receiver’s diagnosis, navigating the mental health system, managing the care-receiver’s problematic and unpredictable behaviour, or dealing with changes in the nature of the relationship with the advent of mental illness. While experiential avoidance can benefit lay mental health carers in the short term by decreasing distress, it has potential to become problematic when utilised rigidly and without regard to situational appropriateness (Schmalz & Murrell, 2010).

To our knowledge, no published study has examined the relationship between interpersonal problems and experiential avoidance in mental health carers. However, this relationship has been studied in a non-clinical population, with a recent study proposing negative perceptions and expectations of relationships play a mediating role (Gerhart et al., 2014). Negative perceptions and expectations of relationships are strongly held beliefs about self and others that contribute to rigid and patterned interpersonal behaviour (Downey, Freitas, Michaels, & Khouri, 1998). Gerhart et al. (2014) proposed that experiential avoidance holds temporal precedence in predicting negative perceptions and expectations in the form of attachment anxiety and hostility, and in turn, these perceptions are associated with interpersonal problems. Results of a cross-sectional survey indicated attachment anxiety mediated the relationship between experiential avoidance and interpersonal problems involving coldness and social avoidance, and hostility mediated the relationship between experiential avoidance and interpersonal problems involving dominance and vindictiveness (Gerhart et al., 2014).

Gerhart et al.’s mediation model (2014) fits with our understanding of the impact of experiential avoidance, attachment anxiety and hostility on relationships. Experiential avoidance is known to have a detrimental impact on cognitions regarding self and others (Crístea et al., 2013) and is associated with increased tension, conflict and inhibited intimacy in relationships (Reddy, Meis, Erbes, Polusny, & Compton, 2011). Attachment anxiety has been linked to increased conflict and reduced disclosure within relationships (Bradford, Feeny, & Campbell, 2002; Campbell, Simpson, Boldry, & Kashy, 2005), as well as reduced likelihood of support and reduced frequency of helping behaviour (Carnelley, Pietromonaco, & Jaffe, 1996). Hostility has a negative impact on relationships, through increased interpersonal rejection (Dodge & Coie, 1987; Karasawa, 2003) and maladaptive interpersonal cognitions (Scott, Ingram, & Shadel, 2003). Moreover, these processes have significance for the broader carer population. Studies show that carer attachment is associated with experiences of burden (Carpenter, 2001), anxiety (Cooper, Owens, Katona, & Livingston, 2008), psychological morbidity (Crispi, Schiaffino, & Berman, 1997), and psychological health (Nelis et al., 2012). Research on hostility in carers has primarily occurred in the framework of expressed emotion (a critical, hostile or controlling style of behaviour) and indicates high levels of criticism are common in carer family environments (Bailey & Grenyer, 2015); and expressed emotion is linked with higher burden and distress for carers (González-Blanch et al., 2010).

Gerhart et al.’s (2014) conceptual model of interpersonal problems has applicability to the mental health lay carer population. Caregiving for someone with mental illness is associated with difficult experiences (Losada et al., 2015), and high use of experiential avoidance as a means of coping (Chawla & Ostafin, 2007). According to Gerhart et al.’s (2014) model, the more a caregiver avoids thoughts, feelings and sensations related to the person they are caring for, the more anxious they become about the attachment (or alternatively, the more hostile they become). This attachment anxiety and/or hostility shapes the way the mental health carer behaves in their relationships, with rigid and excessive use of behaviour resulting in expression of the eight interpersonal problem
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