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Journal of Behavior Therapy and Experimental Psychiatry

journal homepage: www.elsevier.com/locate/jbtep

The role of experiential avoidance, psychopathology, and borderline personality features in experiencing positive emotions: A path analysis

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ARTICLE INFO

Article history:

Received 4 October 2011

Received in revised form

18 July 2012

Accepted 25 July 2012

Keywords:

Experiential avoidance

Borderline personality disorder

Positive affect

Negative affect

Online study

Path analysis

ABSTRACT

Background and objectives: Experiential avoidance (EA) is an important factor in maintaining different forms of psychopathology including borderline personality pathology (BPD). So far little is known about the functions of EA, BPD features and general psychopathology for positive emotions. In this study we investigated three different anticipated pathways of their influence on positive emotions.

Methods: A total of 334 subjects varying in general psychopathology &/or BPD features completed an online survey including self-ratings of BPD features, psychopathology, negative and positive emotions, and EA. Measures of positive emotions included both a general self-rating (PANAS) and emotional changes induced by two positive movie clips. Data were analyzed by means of path analysis.

Results: In comparing the three path models, one model was found clearly superior: In this model, EA acts as a mediator of the influence of psychopathology, BPD features, and negative emotions in the prediction of both measures of positive emotions.

Discussion: EA plays a central role in maintaining lack of positive emotions. Therapeutic implications and study limitations are discussed.

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1. Background

A central characteristic of borderline personality disorder (BPD) is emotional dysregulation. With regard to this construct, empirical studies found on the one hand intense emotional reactions to BPD-related stimuli such as abuse or abandonment (Arntz, Klokman, & Sieswerda, 2005; Ebner-Priemer et al., 2005; Lobbstaël & Arntz, 2010). On the other hand, BPD patients generally experience all kinds of increased negative emotions including anger (Gardner, Leibenluft, O'Leary, & Cowdry, 1991), anxiety (Gratz, Tull, & Gunderson, 2008), sadness, and shame (Rüsch et al., 2007; overview in Rosenthal et al., 2008). Negative affect is particularly relevant in BPD, since negative feelings are strongly associated with other BPD symptoms (Kamphuis, Ruyling, & Reijntjes, 2007; Rosenthal, Rasmussen Hall, Palm, Batten, & Follette, 2005). Furthermore, among the range of BPD symptoms, affective

symptoms reflecting areas of chronic dysphoria (e.g., anger and loneliness/emptiness) are among the most stable ones (Zanarini et al., 2007).

Studies in BPD usually focus on negative affect. Only few studies so far investigated the level of positive affect in BPD as well, although positive emotions may take a different course than negative emotions depending on the situation in BPD (Chapman, Rosenthal, & Leung, 2009). Three studies found decreased positive affect in BPD (Dammann et al., 2011; Gratz, 2006; Lenzenweger, Clarkin, Fertuck, & Kernberg, 2004). Reed and Zanarini (2011) investigated positive affective and cognitive states in BPD patients thoroughly and found that BPD patients are far less likely to report experiencing positive states of an affective, cognitive, and mixed nature as compared with axis II comparison participants. These studies all relied on interview and questionnaire data regarding positive emotions. By contrast, one study using emotion induction did not find differences in positive reactivity in BPD as compared to healthy and depressive controls (Jacob et al., 2009). A stronger focus on positive emotions might possibly be very rewarding, as positive emotions can trigger an upward spiral of emotional well-being rather independently of negative emotions (Fredrickson & Joiner, 2002). Furthermore, a high level of positive emotions increases

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stress resilience (Tugade & Fredrickson, 2004; Tugade, Fredrickson, & Barrett, 2004) and sociability (Eid, Riemann, Angleitner, & Borkenau, 2003), and buffers against depression (Wichers et al., 2007); problems in all these domains are typical for BPD. Accordingly, positive psychotherapy, which is based on the principles of positive psychology, has shown to be effective at least in depression (Seligman, Rashid, & Parks, 2006). Thus, increasing positive emotions in BPD may be an important goal of psychotherapy.

However according to clinical experience, high emotion avoidance of BPD patients tends to interfere with emotional work in psychotherapy. A related psychological construct may be experiential avoidance (EA), which gained increasing attention during the last decade. EA is defined as the constant effort to escape and avoid (unpleasant) emotions, thoughts, memories, and other private experiences (Hayes, Wilson, Strosahl, Gifford, & Follette, 1996). Avoidance of emotional experiences is in general regarded as an important maintaining factor of psychological problems. Accordingly, the construct of EA has high overlap with the psychodynamic concept of defense mechanisms, which are also conceptualized as ways to avoid unpleasant affect and discomfort that resulted from conflicting emotions and motivations (Kramer, 2010). Changing these defensive processes to more mature forms are thought to be a key aspect of psychodynamic treatment. Similarly, experiential therapies argue for the benefits of being fully aware and open to one's entire experience (Greenberg, Watson, & Lietaer, 1998). Furthermore, in the social psychology literature James Gross and colleagues have articulated an emotion regulation model that contrasts suppression based regulation (similar to EA and found to be more harmful in the long run) from reappraisal based strategies (seen as more adaptive in the long run) (overview in Gross, 2002) and research in coping showed the adaptive value of approaching emotional experiences (Austenfeld & Stanton, 2004).

In this study we use the concept of EA, since it is one-dimensional and can therefore easily be integrated with other constructs. Furthermore it has been used in many studies investigating pathogenetic processes in psychological disorders, particularly in BPD, and can easily be assessed via self-ratings. Recent theories suggest a functional role of EA in maintaining psychopathology, mainly negative emotions. Probably EA can be seen as a dysfunctional way of regulating negative emotions (Sloan, 2004) for example in social phobia (Kashdan, Breen, Afram, & Terhar, 2010), chronic pain (Costa & Pinto-Gouveia, 2010), post traumatic stress disorder (Marx & Sloan, 2005), and low self-esteem (Udachina et al., 2009). With regard to positive emotions, EA disrupts pleasant and spontaneous activities and decreases positive affective experiences (Kashdan, Barrios, Forsyth, & Steger, 2006). Thus EA may be part of a vicious circle, both maintaining negative affect and blocking positive affect (Fledderus, Bohlmeijer, & Pieterse, 2010).

In BPD, EA is higher than in psychotherapy outpatients without personality disorder (Gratz et al., 2008) and is closely connected to BPD symptoms including deliberate self-harm, which has the function to avoid aversive experiences (Chapman, Gratz, & Brown, 2006; Gratz et al., 2008; Hulbert & Thomas, 2010; Rosenthal et al., 2005). Furthermore, high EA impairs treatment in BPD, being a predictor for dropout from treatment (Rüsch et al., 2008), and leading to less improvement of depressive symptoms over psychological treatment (Berking, Neacsiu, Comtois, & Linehan, 2009).

However, many questions concerning the meaning of EA in BPD are still open. On the one hand, most studies are correlational and thus cannot test underlying processes (Chawla & Ostafin, 2007). On the other hand, both EA and BPD severity are generally correlated with emotional problems and particularly with psychopathology (Chawla & Ostafin, 2007; Rosenthal et al., 2008). Associations

between EA and BPD features might be explained by this overlap as well. To the best of the authors' knowledge, it has not been investigated so far, how BPD features, EA, and psychopathology were associated with the expression of positive emotions and emotional reactivity. Whether either the severity of BPD features or the extent of experiential avoidance plays a mediating role for the expression of positive emotions may have implications for the focus of psychotherapy.

Based on these considerations, the aim of this study is to investigate the role of EA, BPD features, psychopathology, and negative emotions in explaining the lack of positive emotions in people with high BPD features. At this time, three hypotheses concerning the relationship between these variables can be assumed (depicted in Fig. 1): (1) High BPD features and the related emotional dysregulation cause EA, and EA inhibits positive emotions (Kashdan et al., 2006). Since both negative affectivity and high psychopathology are typical, but not specific of BPD, these two variables function as additional predictors for EA in this model (model 1). (2) Studies show a negative influence of high EA on the course of BPD (Berking et al., 2009; Rüsch et al., 2008). Therefore, in model 2, EA affects BPD features, and BPD features have a negative impact on positive emotions. Again, general psychopathology and negative affectivity are regarded as unspecific predictors of BPD features. (3) Since negative affect is at the core of BPD, and EA may mainly serve to regulate aversive emotions (Cheavens et al., 2005; Gratz et al., 2008; Hulbert & Thomas, 2010), model 3 hypothesizes negative emotions as the main factor influencing EA. In this model, EA has an impact both on BPD features and lack of positive affect.

Given these three possible pathways how the levels of BPD features, psychopathology, negative emotions and EA could be

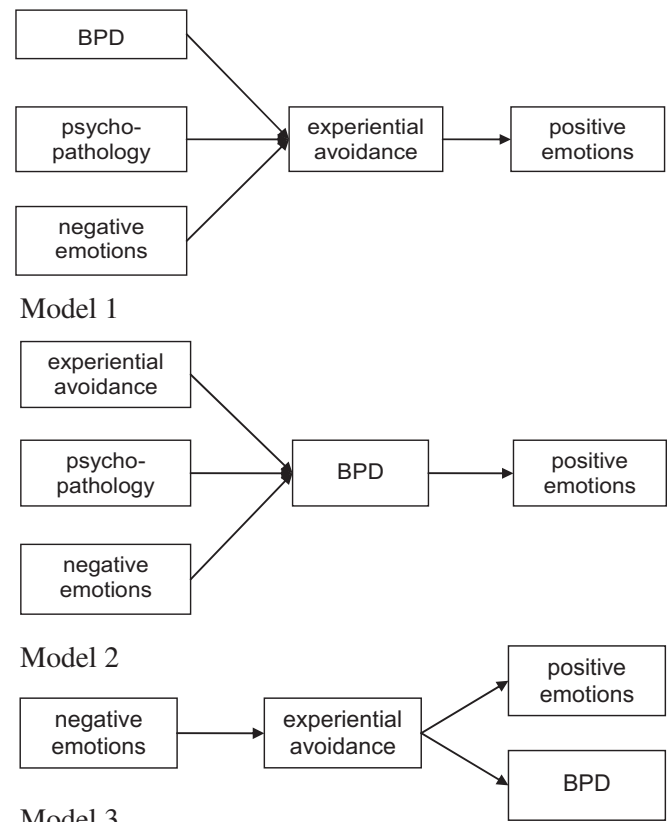


Fig. 1. Three different models of the relationship between experiential avoidance, borderline personality disorder (BPD) symptoms, psychopathology, negative emotions and positive emotions.

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