

RELATIONSHIP AMONG EXPERIENTIAL AVOIDANCE, COGNITIVE EMOTION REGULATION STRATEGIES, AND DEPRESSION: THE MODERATING ROLE OF MALADAPTIVE STRATEGIES

pISSN: 2957-8507
eISSN: 2957-8493



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DOI: <https://doi.org/10.36755/themind.v2i1.96>

Abstract

Depression is a prevalent psychiatric illness and a leading cause of disability worldwide. Experiential Avoidance (EA) and maladaptive cognitive emotion regulation (CER) strategies are significant predictors of depression, yet their interaction remains poorly understood. This study aimed to investigate the relationship between experiential avoidance, CER strategies, and depression, while examining the arbitrating role of maladaptive CER strategies in the association between EA and depression. A purposive sample of N= 354 patients diagnosed with Major Depressive Disorder was recruited from three teaching hospitals. Following research and clinical ethics protocols, measures were administered. Results revealed that participants in the treatment group N=38 demonstrated statistically significant improvement in depression, general health, and quality of life, with sustained effects observed at 9 months post-baseline. Additionally, participants in the treatment group reported higher treatment satisfaction compared to the control group N=38. Spiritual-integrated cognitive-behavioral therapy (CBT) shows promise in alleviating post-partum depression when compared to treatment as usual. Future research should explore the generalizability of these findings and investigate potential mechanisms underlying the effectiveness of spirituality-integrated CBT in treating depression.

Keywords: *Spirituality, Cognitive Behavior Therapy, Post-Partum Depression*

INTRODUCTION

The World Health Organization states that depression is the most frequent mental disorder worldwide. Over 300 million individuals worldwide, spanning all age groups, experience depression. Depression is the leading cause of disability worldwide, and is a major contributor to the overall global burden of disease (Zolfaghari & Heydari, 2021). By the year, major depressive episode is likely to be the leading cause of the burden of disease. 2030 (Ince et al., 2019). Depression is one of the most prevalent undiagnosed mental health issues in Pakistan. It is often concealed by long-term conditions and psychological disorders, and it significantly worsens the prognosis of chronic illnesses. In general, women have a 10%–25% chance of having depression, while men have a 5%–12% risk (Shorey & Wong, 2022).

One of the significant predictors of depression is Observed (Experiential) Avoidance (Rezaei & Ghazanfari, 2016). Evading is the well approach to escape conflict, and the best long term strategy to confirm suffering (Mellick, 2017). EA is the deliberate endeavor to avoid feeling the feelings and experiences connected to unwelcome internal ideas or memories. material already in existence supporting a link between emotional and/or internal suffering and experience avoidance. When unpleasant emotions are avoided for an extended period of time, the perceived distress that goes along with them may seem more intense (Forbes, 2020).

Additionally, they contend that people with high levels of experience avoidance often perceive undesirable stimuli as more dynamic, which raises the risk of having issues with emotion regulation. This process how a person reacts to and controls the unpleasant feelings that follow stressful encounters or events is commonly referred to as emotion regulation (Williamson, 2020). Many responses, including behavioral, cognitive, and physiological ones, can be used, consciously or unconsciously, to control unpleasant emotions. When an emotion-eliciting event occurs, cognitive emotion regulation methods are cognitive reactions that aim, either intentionally or unintentionally, to change the nature, intensity, before scope of the individual experience. CERs are necessary in order to manage these stressful conditions and unfavorable life circumstances (Carl et al., 2018). Psychopathological symptoms, such as depression and anxiety, will arise if the person is unable to use CER to get over these stressful situations or unpleasant feelings. (Garnefski & Kraaij, 2018).

Strategies (adaptive and maladaptive) of CER play an important role here. The adaptive strategies like acceptance, reappraisals, positive refocusing, refocus on planning leads to positive mental health outcomes, including decreased negative emotions, anxiety depression (Smith & Diedrich, 2024).). The maladaptive strategies like self- blame, other- blame, rumination, catastrophizing lead to emotional problems and depression. So, it has been established that EA leads to depression and EA leads to CER discrepancies. So far, no published literature is known

to find interaction between the three. Thus, the present study was aimed to find association between experiential avoidance, CER strategies and depression and if maladaptive CER strategies, particularly maladaptive ones, are playing as a moderator in relationship between EA and depression (Kardiansyah, 2020).

The rationale for this study is grounded in the significant global burden of depression, which is anticipated to become the leading cause of disability by 2030, with Pakistan experiencing challenges in identifying and addressing this mental health issue. EA has been identified as a key predictor of depression, involving deliberate efforts to evade unwelcome internal thoughts and emotions, potentially exacerbating distress. Additionally, EA is linked to discrepancies in cognitive emotion regulation (CER) strategies, which are crucial for managing stress and adverse life events (Herrera, 2021).

While adaptive CER strategies contribute to positive mental health outcomes, maladaptive ones, such as rumination and catastrophizing, are associated with emotional problems and depression. Despite this understanding, there is a gap in the literature considering the interaction between experiential avoidance, CER strategies, and depression, particularly regarding the potential moderating role of maladaptive CER strategies. Therefore, this study seeks to investigate the associations between experiential avoidance, CER strategies, and depression, as well as explore whether maladaptive CER strategies serve as a moderator in the relationship between EA and depression. By addressing this gap, the study aims to supportive mechanisms underlying depression and inform more effective interventions and prevention strategies (Malik & Perveen, 2023).

Underpinning Theory/Model

Emotion Regulation Theory

This theory suggests that individuals employ various strategies to modulate their emotional experiences, and deficits or dysregulation in emotion regulation can lead to psychological distress, including depression. EA and maladaptive CER strategies represent dysfunctional ways of managing emotions, contributing to depressive symptoms (Chang, 2020).

Model of the Study

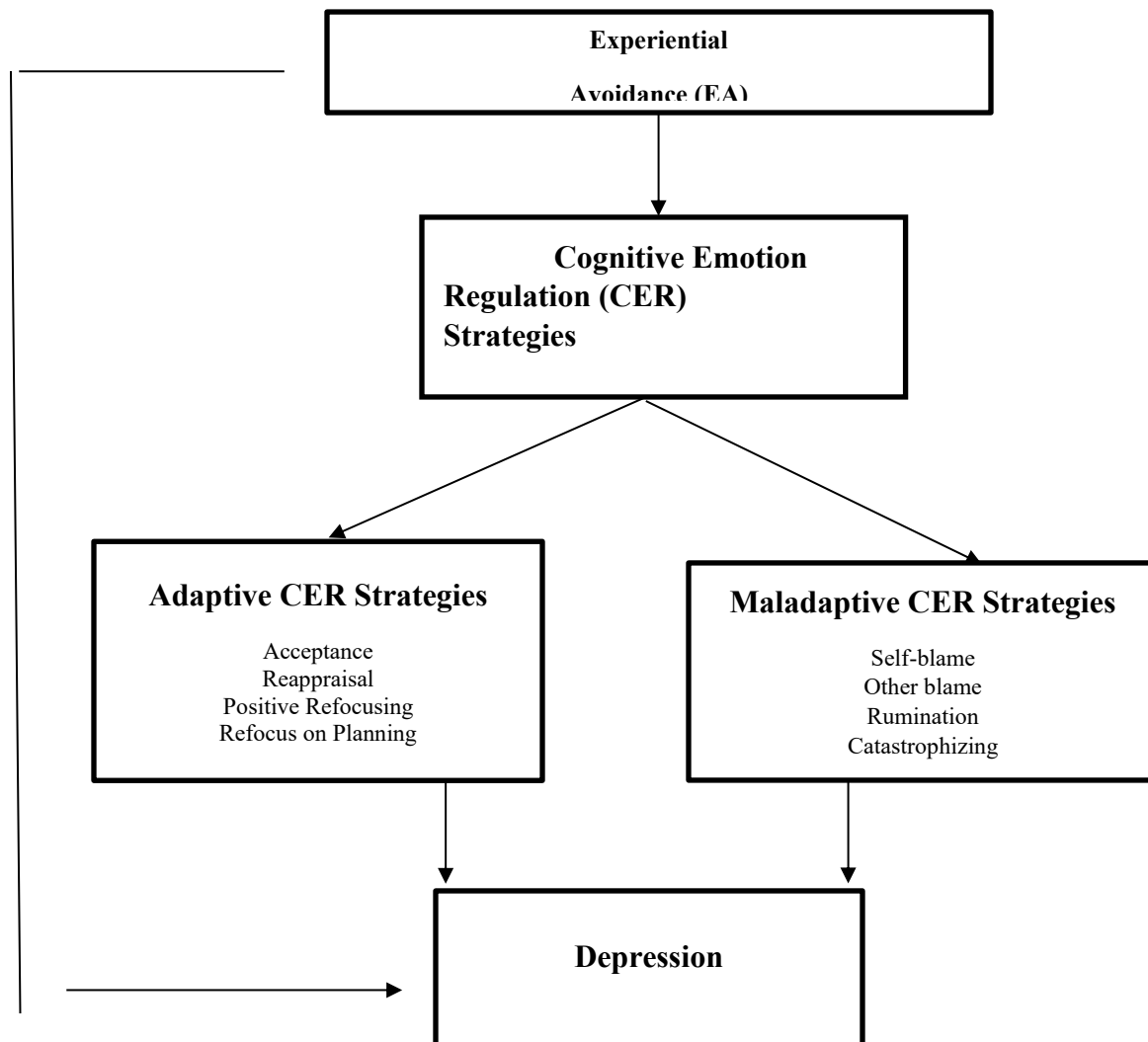


Fig 1: Model of the Study

The model of study illustrates the interplay between EA, CER, and Depression. EA serves as a pivotal factor directly linked to Cognitive Emotion Regulation (CER). Within CER, individuals employ both Adaptive and Maladaptive strategies to manage their emotions. Adaptive strategies, such as the positive reappraisal or the problem-solving, aim to effectively cope with emotional experiences, while the maladaptive strategies, including rumination or suppression lean to worsen emotional distress in this model. Both the types of CER strategies can have significant

implications for Depression, with Adaptive strategies Therefore, understanding the relationship between EA, CER strategies, and Depression is crucial for developing targeted interventions aimed at promoting adaptive emotion regulation and mitigating depressive symptoms.

Hypotheses

H1: There is a significant positive relationship between experiential avoidance (EA) and depression among patients diagnosed with Major Depressive Disorder.

H2: Maladaptive cognitive emotion regulation (CER) strategies moderate the relationship between experiential avoidance (EA) and depression.

Method

Sample

This study was conducted from October 2018 to April 2019. Purposive sampling technique was used to collect data of 354 adult patients (males=84, females=266) with age of 18 years and above, because researchers only intended to study these constructs in adult patients, diagnosed with Major Depressive Disorder. The sample was collected from two teaching hospitals in Lahore and one teaching hospital from Multan. The diagnosed patients were referred by the hospital staff, also the diagnosis was confirmed by researchers on basis of Diagnostic and Statistical Manual (Association, 2013). The data was self-reported by patients. The research ethics such as informed consent, debriefing, and true to withdraw from the study were followed in the study.

Instruments

Three measures were used in this study, and the following are being discussed.

1. **Acceptance and Action questionnaire (AAQ-II)** consists of 7 items, one factor tool to measure experiential avoidance. Higher scores equal greater experiential avoidance. AAQ II has good internal consistency ($\alpha = 0.88$) and good test retest reliability over 3 and 12 months at 0.81 and 0.79 respectively. This scale developed by Hayes, S. C., Strosahl, K. D., & Wilson, K. G in 2004.
2. **Cognitive Emotion regulation Questionnaire (CERQ)** contains of 36 item Likert scale and 9 subscales that measure how frequently certain cognitive strategies are used to cope with stressful life events. In this study, rumination, self-blame, blaming others and subscales that catastrophize were applied. The sub-scales have corresponding Cronbach's alpha coefficients of 0.85, 0.81, and 0.70. This scale developed by Garnefskin & Kraaij in 2007.
3. **Siddiqui Shah Depression Scale (SSDS)** is a 4-point Likert scale ranging from 1=never to always=4, designed to measure severity of depression and can also differentiate between

depressed and non-depressed. The scale has shown good alpha values from .84 to .91. This scale developed by Siddiqui Shah in 2015.

Procedure

The data was self-reported by patients. The research ethics such as informed consent, debriefing, and right to withdraw from the study were followed by the researchers. The data collected was analyzed through SPSS to test the study hypotheses.

Results

Table 1

Means, Standard Deviations and Correlations of Study Variables (N=354)

Variables	1	2	3	4	5	6
Experiential Avoidance	-	.72**	.65**	.51**	.64**	.88**
Rumination		-	-	-	-	-
Catastrophizing			-	-	-	-
Self-Blame				-	-	-
Blaming Others					-	-
Depression						-
<i>M</i>	37.01	13.47	13.61	13.53	13.01	47.08
<i>SD</i>	4.49	2.60	2.55	2.56	2.53	15.04

** $p < .01$

Table 1 indicates significant correlations among all variables, highest between EA and depression ($r = .88$) and lowest between EA and self-blame ($r = .51$). Hierarchical Multiple Regression was used to find moderating effects of CER Strategies in relationship between EA and Depression (Howitt & Cramer 2017).

Table 2

Hierarchical Multiple Regression to find Moderating Effects of Cognitive Emotion Regulation Strategies (N=354)

Model	Predictor	Unstandardized Co-efficient		Standardized Co-efficient		R^2	R^2 Change	F	P
		B	SE	B	P				
1.	EA	3.12	.09	.88	.000	.776	.776	1221.99	.000
	EA	1.44	.12	.40	.000	.884	.110	541.15	.000
	SB	1.08	.17	.17	.000				
2.	BO	1.77	.28	.28	.000				
	C	1.28	.16	.20	.000				
	R	.58	.16	.09	.000				

Note: EA= Experiential Avoidance, SB= Self-blame, BO= Blaming others, C= Catastrophizing, R= Rumination. ** $p < .01$ * $p < .05$

Table 2 indicates that EA is a significant predictor of Depression; R^2 Value of model 1 suggests that 77% depression is due to Experiential Avoidance. The model was significant ($F = 1221.99$, $p < .001$). However, model 2 shows that EA and CER strategies combined predict 88% of depression. Model 2 is also significant ($F = 541.15$, $p < .001$). This shift from 77% prediction in model 1 to 88% prediction in model 2 significantly shows moderating effects ECR strategies. Thus, cognitive emotion regulation strategies prove to be significant moderator in relationship between EA and depression (Howitt and Cramer 2017).

DISCUSSION

Depression, as a widespread psychiatric condition, significantly impacts individuals' daily lives and overall well-being. It is essential to comprehend the intricate interplay between Experiential Avoidance (EA), Cognitive Emotion Regulation (CER) strategies, and depression for effective intervention strategies. Previous research has highlighted EA and maladaptive CER strategies, such as rumination and catastrophizing, as crucial predictors of depressive symptoms.

However, the specific mechanisms underlying their interaction and collective influence on depression necessitate further exploration.

The findings of this study corroborate existing literature, indicating a positive association between EA and depression. Individuals who engage in deliberate efforts to avoid distressing emotions or thoughts are more likely to experience heightened depressive symptoms over time. Moreover, maladaptive CER strategies, including rumination and catastrophizing, have been linked to increased vulnerability to depression. These findings align with previous research, emphasizing the detrimental impact of maladaptive coping strategies on mental health outcomes.

Interestingly, this study also sheds light on the moderating role of maladaptive CER strategies in the relationship between EA and depression. It suggests that the association between EA and depression is stronger when individuals employ maladaptive CER strategies. This finding underscores the importance of considering the interplay between coping mechanisms and emotional experiences in understanding depressive symptomatology. Building upon these insights, future research should further explore the underlying mechanisms through which EA and maladaptive CER strategies contribute to depression. Longitudinal studies could elucidate the temporal dynamics of these relationships, providing valuable insights into the etiology and maintenance of depression. Additionally, experimental research could investigate the efficacy of interventions targeting EA and promoting adaptive CER strategies in alleviating depressive symptoms. Moreover, it is crucial to consider the broader contextual factors that may influence the relationship between EA, CER strategies, and depression. Socioeconomic status, cultural norms, and social support systems play integral roles in shaping individuals' coping strategies and mental health outcomes. Therefore, future studies should adopt a more comprehensive approach that incorporates these contextual variables into their analyses.

Implications

The study's conclusions have a number of ramifications for clinical practice and research. First off, it is critical to address these characteristics in treatments aimed at reducing symptoms of depression because of the strong correlations observed between depression, maladaptive cognitive emotion regulation techniques, and experiential avoidance. Interventions focusing on reducing EA and promoting adaptive CER strategies may prove beneficial in preventing and treating depression. Furthermore, to effectively lessen the effects of EA on depression, therapies should think about focusing on these particular techniques, as evidenced by the moderating role of maladaptive cognitive emotion regulation strategies. In addition, the study's longitudinal design sheds light on the temporal interconnections among these variables, highlighting the necessity of long-term therapies that target these variables in order to stop depressive episodes from starting or returning.

Limitations

Despite the valuable insights gained from this study, several limitations should be acknowledged. Firstly, the study relied on self-report measures, which may be subject to response biases and inaccuracies. Future research could benefit from incorporating objective measures or multiple informants to provide a more comprehensive understanding of the relationships between EA, CER strategies, and depression. Furthermore, the sample consisted of patients diagnosed with Major Depressive Disorder, limiting the generalizability of the findings to other populations or psychiatric disorders. Future studies should replicate these findings in diverse samples to enhance the external validity of the results. Lastly, the study's reliance on correlation analyses precludes causal interpretations of the relationships observed. Longitudinal or experimental designs could provide stronger evidence for causal relationships between these variables.

Suggestions

Constructing on the outcomes of this study, several ways for future research can be identified. Firstly, longitudinal studies are needed to further elucidate the temporal relationships between EA, CER strategies, and depression. Longitudinal designs would allow for the examination of how changes in these variables over time predict changes in depressive symptoms. Secondly, experimental studies could investigate the efficacy of interventions targeting EA and cognitive emotion regulation strategies in reducing depression. Randomized controlled trials could compare the effectiveness of different intervention approaches, such as cognitive-behavioral therapy, mindfulness-based interventions, or acceptance and commitment therapy. Lastly, qualitative research could provide insights into individuals' subjective experiences of EA and cognitive emotion regulation strategies, enhancing our understanding of these constructs in the context of depression.

CONCLUSION

In conclusion, this study adds to the existing literature by elucidating the relationships between EA, maladaptive CER strategies, and depression. The findings underscore the significance of addressing these factors in interventions aimed at preventing and treating depression. Specifically, interventions targeting EA and promoting adaptive cognitive emotion regulation strategies may hold promise in alleviating depressive symptoms. Moreover, the moderating role of maladaptive cognitive emotion regulation strategies highlights the importance of tailoring interventions to address these specific strategies to effectively mitigate the impact of EA on depression outcomes.

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