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# Interpersonal problems amongst mental health carers: a qualitative study

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Interpersonal Problems Amongst Mental Health Carers

## Interpersonal Problems Amongst Mental Health Carers: A Qualitative Study

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### Abstract

Mental health carers are affected by the relationship with the person for whom they provide care, and these interpersonal aspects of caregiving have received limited attention. This paper explores mental health carer's experiences of interpersonal problems within their caring relationship. Qualitative methodology was used, with semi-structured interviews based on biographical narrative and Core Conflictual Relationship Theme framework. Participants were 28 adult carers of people with mental health problems. Thematic analysis identified the following themes: emotion management, aggression, avoidance, responsibility, control, communication and role challenges. Findings indicate mental health caregivers experience a myriad of interpersonal problems and raises implications for policy and clinical practice.

Keywords: caregiving, mental health, qualitative, interpersonal problems

## Introduction

The term ‘carer’ refers to any person who provides regular unpaid support to another person experiencing illness or disability, which may, for example, be associated with physical, intellectual or psychosocial disability, mental illness, or ageing. This paper will focus on a specific subset of the carer population- those “lay carers” who provide caring for a loved one experiencing mental illness. Mental health carers have a role that is inherently different to other caring contexts: unpredictable, episodic and demanding a high degree of flexibility and responsiveness from the carer (Broady & Stone, 2015). The trajectory of mental health for the person with mental illness fluctuates between unwellness and recovery and can include significant functional impairments, periods of hospitalisation, and the need for medication (Jans & Kraus, 2004). Moreover, mental health carers own coping and wellbeing fluctuates alongside the care receiver; with carers experiencing cycles of negative affect, burnout, and worry about the wellbeing of their care receiver (Jeon, Brodaty, & Chesterson, 2005; Jeon & Madjar, 1998). The negative impact of this role is substantiated in the literature.

There are varying definitions as to the role of a mental health carer. For example, the NSW Carers Recognition Act (2010) defines a mental health carer as ‘an individual who provides ongoing personal care, support and assistance to any other individual who needs it because that individual has a mental illness’ (p. 4). Common to all definitions of mental health caregiving is the interconnection between two people. This connection may be that of a parent, sibling, adult child, other relative, partner, friend, etc. The definition of ‘mental health carer’ remains a point of contention, with some carers voicing concerns that the term unnecessarily professionalises their relationship. For many mental health carers their caring role is conceptualised as an extension of their existing relationship, e.g. ‘I’m not a carer, I’m a mother’, (Jeanette Henderson, 2001). A common criticism of the ‘carer’ definition is that it

focuses on practical tasks associated with the role, with the interpersonal component overlooked (J. Henderson & Forbat, 2002; Sadler & McKeivitt, 2013). In response to these observations, there has been a push for the recognition of the interpersonal aspects of mental health caregiving within Australian social policy and the carer research literature.

Australian social policy has seen a shift in focus towards recognising and supporting mental health carer relationships. In 2006 the Victorian Government explicitly prioritised the carer relationship through the 'Recognising and supporting carer relationships' policy framework (Department of Human Services, 2006). The policy emphasises the importance of current relationship dynamics, relational history and reciprocity in understanding the carer role. The NSW Carers Charter (Carers Recognition Act, 2010) outlines thirteen principles to guide work with carers, one of which states 'the relationship between carers and the person for whom they care should be respected' (p. 6). These policies reflect a move away from simply considering individuals in isolation.

The literature on mental health caregiving has primarily focused on the themes of individual carer needs and carer burden, with Penning, Wu and Zheng (2016) noting that limited attention has been directed towards the implications of the carer relationship for an understanding of carer outcomes. Chattoo and Ahmad (2008) suggest this represents a theoretical bias towards a dichotomous notion of caregiving- with the separate emphasis on the 'carer' and 'person needing care' limiting our understanding of the carer dyad as an interrelated process.

In light of growing consensus that models of stress and coping need to incorporate a relational perspective (Kayser, Watson, & Andrade, 2007), the last decade has seen an increased focus on the complex interpersonal patterns that exist between carers and care receivers. As work in this field is emerging, little research has been specific to mental health

carers. Notable examples within the broader carer field include exploration of relationship dynamics and role changes within cancer care dyads (Ussher, Wong, & Perz, 2011), the interpersonal experiences of caring for a mentally unwell spouse (Lawn & McMahon, 2014), the interpersonal experiences and sense of couplehood within spouse dementia carer dyads (Wadham, Simpson, Rust, & Murray, 2016), and attachment patterns within dementia carer dyads (Nelis, Clare, & Whitaker, 2012). Our understanding of the unique interpersonal qualities of mental health carer dyads remains an area for further investigation.

It makes intuitive sense that mental health carers are affected by the relationship with the person for whom they provide care. The nature of this relationship undergoes significant changes as the caregiving role is initiated, with the balance of power changing as the parties become the 'caregiver and the care receiver' (Oyebode, 2003). During this adjustment time the new relationship, its boundaries and expectations need to be navigated. These changes can result in a form of 'complicated grief' where the mental health carer holds ambivalent feelings towards the care receiver and is left with a sense of betrayal or loss in that the person they once knew is changed, as is the imagined future for, and with, that person (Campling & Jones, 2001). Such feelings and ambivalence, along with changed roles, can be a source of interpersonal problems for the mental health carer to navigate.

The quality of relationship between the carer and care receiver has a direct influence on caregiver coping and whether continued care is provided (Nele Spruytte, Van Audenhove, & Lammertyn, 2001). The protective benefits of positive carer/care receiver relationships have been indicated across numerous studies, with connection and attunement linked to carer coping and resiliency (Wadham et al., 2016), intimacy and love associated with lower levels of carer psychotic symptoms and burden (Braithwaite, 2000), and positive ratings of the relationship associated with lower levels of carer stress and depression (Oyebode, 2003). A challenge for mental health carers is maintaining quality relationships in the context of a care

role that can be chaotic and unpredictable, and that brings with it a unique set of interpersonal problems to navigate.

Interpersonal problems have been defined as 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 (Sullivan, 1953). Interpersonal theory is based on the assumption that one should focus on interpersonal processes in order to understand pathological behaviour (Horowitz et al., 2006; Leary, 2004; Sullivan, 1953). Interpersonal processes are described as existing along two principal dimensions: affiliation, which ranges from hostile behaviour to friendly behaviour; and control, which ranges from submissive behaviour to dominating behaviour (Alden, Wiggins, & Pincus, 1990).

Interpersonal theory posits that interpersonal situations- in this case the caregiving role- exist in dynamic “recurrent patterns” (Sullivan, 1953, p. 111). From an interpersonal perspective, the emphasis is not on what someone is (i.e., a ‘carer’ or ‘care receiver’) but rather on what someone does. It is in these interactions- involving what carers and care receivers do with each other- where dysfunction and problems are most poignantly expressed (Pincus & Wiggins, 1990).

Work on understanding and classifying interpersonal problems has been pioneered by Horowitz (Horowitz, 1979; Horowitz, Alden, Wiggins, & Pincus, 2000; Horowitz et al., 2006). To develop a framework of interpersonal problems, Horowitz (1979) recorded intake interviews of clients presenting for psychotherapy. Two observers recorded statements of interpersonal problems made by these individuals, resulting in 127 problems that manifested in two ways. Firstly, behaviour one consistently finds ‘hard to do’ - inhibitions or skill deficits that are often expressed as ‘it is hard for me to do X’ or ‘I can’t do Y’. Secondly, behaviours

one 'does too much' - excesses or compulsions often expressed as 'I do X too much' or 'I can't stop doing X' (Horowitz, 1979; Gurtman, 1992; Horowitz et al., 2000).

The purpose of this study was to explore mental health carers accounts of interpersonal problems within their caring relationship. Grounded in Horowitz's (Horowitz, 1979) conceptualisation of interpersonal problems, this study explored which behaviours carers 'find hard to do' and those behaviours carers perceive they 'do too much' in their caring relationship. Our research question was 'What are mental health carers experiences of interpersonal problems within their relationship with the care-receiver?'. This was an exploratory study, in a topic area with little previous work. Our chosen methodology was thematic analysis, with data collected via semi-structured interviews with mental health carers. This study was approved by the University of Wollongong ethics committee.

## **Method**

### *Participants*

Participants met the following inclusion criteria: a) 18 years or older, b) self-identify as a carer of someone with a mental health disorder, c) self-identify as experiencing relationship difficulties with the person they provide care for. Recruitment took place across three carer support agencies between 2015 and 2017 and targeted mental health carers on the waiting list for relationship support programs. Staff members explained the purpose of the study and asked for permission to pass on contact information to the researchers, who then made contact to provide further information, answer questions about the study, and organise the practicalities of the interview. All interviews were conducted at the carer agency that the carer was accessing.

### ***Data Collection***

Interviews had an introductory sequence which consisted of a discussion explaining informed consent, confidentiality and the context of the carer's referral. The first component of the interview began with an invitation for the carers to 'describe your relationship with [care receiver], and how and why it is/was a problem for you'. Based on Rosenthal and Fischer-Rosenthal's (2004) biographical narrative method, the aim was to elicit a detailed narrative indicating how the carers viewed their relationship, how they described the emergence of interpersonal problems, and how they presented themselves and the care receiver. During this part of the interview the researcher listened without interruption.

The second component of the interview focused on a recent conflict between the mental health carer and care-receiver, and was based on Core Conflictual Relationship Theme (CCRT) methodology. The CCRT method is derived from Luborsky's theory (1984) that an individual's relational exchanges are underpinned by a typical core conflict. The CCRT method explores this core conflict through exploration of an interpersonal narrative; identifying the individuals wishes/desires, reaction and responses to the other person, and the other persons reaction to them (Luborsky & Crits-Christoph, 1998). Our framework for exploring this took place in a narrative of recent conflict between the mental health carer and care-receiver, with set questions utilised to explore the above areas. The full set of questions was: a) Can you please describe the event or interaction, and what makes it significant for you? b) What were you thinking and feeling at the time? c) What did you want at the time? What did you want from the other person? d) How did the other person react? e) How did you cope with that? f) What happened in the end? g) What do you hope for in this relationship? How do you want your interactions to be different in the future? Interviews were audio-recorded for the purposes of transcription and lasted between 20 minutes and 75 minutes, with an average length of 34 minutes

## **Analysis**

The 28 interviews were transcribed verbatim and de-identified labels were used in the interest of confidentiality. Thematic analysis was guided by the steps outlined by Braun and Clarke (2006). Following careful reading and re-reading of transcripts, initial codes were developed based on emotional, social and behavioural content expressed by the carers as either 'occurring too much' or that they found 'hard to do'. In developing the codes, the theoretical framing of this study narrowed our analytical focus. Codes followed the following inclusion criteria: a) they needed to be interpersonal in nature; that is, relating to relationships or communication between people; and b) they needed to reflect a difficulty or problem.

To ensure reliability of codes, a manual was formed which listed codes, descriptions, example quotes and emergent categories. These codes underwent successive rounds of comparison, within and across interviews, as we compared their content and meaning in relation to one another and to the dataset in its entirety. During this process the manual was regularly updated, as codes could be amended, subsumed under other codes, or new codes created. The coding framework was refined by clustering codes together under umbrella themes, by identifying what was inherently common to or about them (that is, how they connected). Once the list of themes was finalised, a name was given to each theme thought to capture its essence and the final report was produced.

## **Findings**

### ***Demographics***

The potential sample consisted of 35 mental health carers on the waiting list for relationship support programs. Of these, 4 declined to participate in the study and 3 dropped out whilst scheduling the interview; citing time constraints. Participants (n = 28) were adult mental

health carers. The majority of participants (approximately 78%) were caring for a family member; consisting of parents (60%), adult children (4%), and other relatives (14%). The remaining sample consisted of partners (18%) and other non-relatives (4%). The vast majority of participants were women (86%). Just over half (57%) of participants were long term carers, having cared for the care receivers for over 10 years. Table 1 shows further descriptive information on the sample obtained.

### ***Thematic Analysis***

Thematic analysis identified the following themes from the interview data: 1) emotion management; 2) aggression; 3) avoidance; 4) responsibility; 5) control; 6) communication; 7) role challenges. These themes and incorporated subthemes are set out in the following section. In what follows, quotes from participants are coded according to relationship to care-receiver: parent ('P'), child ('C'), other relative ('OR'), spouse ('S') or other non-relative ('ON'); and length of caring role: those caring for less than ten years defined as shorter term ('ST') and those caring for ten years or greater defined as longer term ('LT').

#### *1. Emotion management (identified by 89% of participants; 115 references total)*

The most prevalent theme- that is, the theme which appeared across the highest number of sources- was emotion management. Emotion management was defined as the ability to readily accept and successfully manage feelings in oneself. Emotion management presented as an interpersonal problem when emotions were presented as existing in 'excesses' and these excesses were described as 'hard to handle'. Emotion management was seen to consist of four subthemes; anger, upset, anxiety and non-specific

##### *1a. Anger*

The first category of emotion management related to anger. Carers described difficulties managing anger (as an emotion or behaviour) within the carer relationship. Anger was the only category of emotion management in which the interpersonal problem was cited as originating from both the carer and care-receiver. Carers described their own interpersonal difficulties in managing anger, illustrated by the following quotes:

I feel a lot of frustration, anger (OR4-LT)

I don't want to react the way sometimes I do, I react really angrily back (P4-ST)

There is probably a hell of a lot of anger and shit in relation to that which I haven't let – dealt with before now (P3-ST)

Carers also described the care-receivers struggles with anger. As noted below:

You'd have to see it to believe how angry he gets (OR2-ST)

He does over-react. It works for him. He storms off, gets really angry and it works because everyone backs off (OR4-LT)

He is quite often, exploding in anger and doing something that he then regrets later (ON1-LT)

#### *1b. Upset*

The second category of emotion management was 'upset'; seen to consist of feelings of unhappiness and despondency. Carers described difficulties in managing these emotions in the context of their caring relationship. As described by three carers:

I just cry [long pause]. And yeah, there's not- there's not much else (P14-LT)

I feel hurt and upset and I ... don't know what to do (P17-LT)

I just get very upset, which I know is not helpful, but that's just what's happening (P4-ST)

#### *1c. Anxiety*

The third category of emotion management was anxiety; seen to consist of feelings of worry, nervousness, or unease. Carers described difficulties managing anxious emotions in the context of their caring relationship. As described by three long term carers:

I have a lot of anxiety towards him because I'm always walking around on eggshells (P10-LT)

When I feel overwhelmed I get panic attacks. That can happen if my husband picks up the phone and I know it's [care-receiver] and it sounds like there's something going wrong. I jump forward and think of the worst (P7-LT)

You would think after fifty years I would not worry still (S5-LT)

*Id. Non-specific*

The fourth category of emotion management was 'non-specific', which encapsulated descriptions that made no reference to a particular emotion. As illustrated in the following quotes, carers often reflected that emotions themselves were hard to handle.

I just have to cope with my emotions a bit better, or, I don't know, try to deal with it a bit better (OR3-ST)

Externally okay, but internally not well... that's why I need help, because I'm not coping very well internally (P17-LT)

2. *Avoidance (identified by 86% of participants; 80 references total)*

The second most common theme across transcripts was avoidance. Avoidance was defined as attempts to suppress unwanted experiences, and to alter the frequency at which they occur. Avoidance presented as an interpersonal problem as it was a behaviour which existed in 'excesses' within the relationship to account for behaviour found 'hard to do'. Avoidance was coded under three subthemes: physical, verbal and internal.

### *2a. Physical avoidance*

The first category of avoidance was physical; defined as removing oneself physically from a situation as a means of coping. Carers described finding it hard to be in close proximity to the care-receiver, and thus physical avoidance was utilised as a coping strategy. Carers often noted that they utilised physical avoidance as a situational response to current conflict, such as:

I was just trying to remove myself so as not – so for it to not escalate (P4-ST)

I just ended up walking out (S1-ST)

Physical avoidance was also described as a pervasive coping strategy, that is, not situationally bound. In this sense, carers utilised physical avoidance in efforts to avoid potential conflict. This is reflected in the following excerpts:

If you are living with someone like that you've got to get out all the time- you don't stay (P2-ST)

The less time we stay the less chance of her getting agitated or anxious (P12-LT)

Physical avoidance was the only category of avoidance in which the interpersonal problem was cited as originating from both the carer and care-receiver. Carers described this pattern of physically distancing as also occurring for the care-receiver. Examples include:

He'll storm off, he'll avoid, avoid, avoid, and avoid (OR4-LT)

He tends to just walk away and I'm saying, "I haven't finished talking to you yet," halfway through a sentence (P13-LT)

### *2b. Verbal avoidance*

The second category of avoidance was verbal; defined as restricting what one says verbally as a means of coping. Carers described finding it hard to communicate with the care-receiver, and thus verbal avoidance was utilised as a coping strategy. As with physical manifestations of avoidance, carers noted that they utilised verbal strategies as a situational response to current conflict. Examples include:

Change the subject mode (P7-LT)

That's why I just shut up (OR2-ST)

Verbal avoidance was also described as a pervasive coping strategy, that is, not situationally bound. In this sense, carers utilised verbal avoidance in excess, in efforts to avoid potential conflict. This is reflected in the following excerpts:

I don't talk to him anymore unless I have to (P5-ST)

If I be quiet, and get out of the house, it's okay (P2-ST)

### *2c. Internal avoidance*

The third category of avoidance was internal; defined as attempts to reduce the frequency and/or intensity of internal experiences such as thoughts, feelings and memories. Carers described finding it hard to manage the internal experiences that arose due to their carer relationship, and thus internal avoidance was used as a means of coping. The internal avoidance described by carers consisted of efforts to numb/dull emotions, or attempting to ignore thoughts and feelings altogether. Carers described the process of internal avoidance as a struggle. This is illustrated by the following quotes:

I try to ignore it; not let it affect me too much. Try to distance myself to a degree (S3-ST)

And just gone about my stuff and just sort of ignored it. I haven't really dealt with it in such a way, but I've kind of ignored it (P15-LT)

The theme of internal avoidance has overlap with that of emotion management. It is argued that these themes, whilst similar in that they both draw on emotions, represent distinct interpersonal problems. The interpersonal problem underlying internal avoidance is the inhibition of internal experiences; thoughts and feelings are experienced as 'hard to handle', leading to struggles with internal avoidance. In contrast, in emotion management the underlying interpersonal problem is difficulty managing excess of emotion.

### *3. Aggression (identified by 82% of participants; 113 references total)*

The third most common theme across transcripts was aggression. Aggression was defined as behaviours that can result in real or perceived physical and psychological harm to oneself, other or objects in the environment. Aggression presented as an interpersonal problem as it was a behaviour which existed in 'excesses' and that was 'hard to handle' within the carer relationship. In all cases where carers discussed incidents of aggression, the support organisation was made aware (with the consent of the carer) and responded in line with existing risk management protocols. Aggression was coded under two subthemes: verbal aggression and physical aggression.

#### *3a. Verbal hostility*

Verbal hostility was understood to be the use of words to harm another or attacks another person's self-concept. Throughout the category of verbal hostility, the interpersonal problem was cited as originating from both the carer and care-receiver. Carers described experiencing an excess of hurtful or insulting comments within the carer relationship. Experiences include:

She'll insult me with a lot of, you're weak, you're going to cry, you're hopeless, things like that... It's the actual words she uses that really hurt (P4-ST)

She says the most nasty vicious things to you and expects you just to forgive her (C1-LT)

He calls me all the names under the sun (OR2-ST)

Verbal hostility was frequently framed as occurring in the context of conflict. Arguments were put forward as a common experience within the relationship. This is illustrated by the following quotes:

You've got her constantly arguing (P5-ST)

I responded with a screaming match (P10-LT)

Just being up in his face and yelling and screaming at him (S1-ST)

### *3b. Physical aggression*

The second category of aggression was physical; seen as threatening behaviour towards another person or an object. Excesses of physical aggression within the relationship were described as originating from the care-receiver, with examples as follows:

She would hit me around the head (S3-ST)

So one day she just pushed me up against a cupboard and without realising it she threw me down the stairs (P2-ST)

He was willing to throw me out of the way... He is willing to be physically violent (P16-LT)

Carers also described physical aggression towards an object as being a common experience within the carer relationship. In describing the care-receiver's interpersonal behaviour, the following carers noted:

He has broken windows before (ON1-LT)

Because she's damaged so much up here, we don't ask her to come intentionally anymore because of the damage she does (P12-LT)

He'll slam the door (P14-LT)

*4. Responsibility (identified by 75% of participants; 93 references total)*

The fourth theme was responsibility. Responsibility was defined as the state of being answerable or accountable for something within one's power or management. Responsibility as an interpersonal problem ranged from an individual taking on too much responsibility to individuals not taking on sufficient responsibility.

Carers noted that responsibility existed in excesses within their relationship with the care-receiver and noted interpersonal problems around having or accepting "too much" responsibility. These struggles with excess responsibility are illustrated by the following:

I would just automatically pick it up and take it on as my responsibility (P3-ST)

There's a lot of reliance on me. I'm the person he comes to (OR4-LT)

I am the one who hears about that, I'm the one who deals with that (P4-ST)

When reflecting on responsibility, many carers perceived that they were solely responsible for the care-receiver's wellbeing. There was a pervasive sense of being the only

one, as reflected in the following excerpts:

I've been the only one that's been here regularly in his life (P10-LT)

I'm the only person there that is going to be able to encourage him to get out of bed, shower, eat, all those sorts of things (P14-LT)

And again in that comes the responsibility of knowing 'well he's going to come to somebody so if I'm not there, who else is going to be there?' (OR3-LT)

Carers noted that there was a lack of responsibility or taking responsibility was 'hard to do' within the carer relationship. These difficulties with responsibility were described as originating from the care-receiver., as follows:

She has got no responsibility- she has got some but not enough to manage on her own (P2-ST)

She kept coming and running to me for help all the time (S3-ST)

There's no capacity on my husband's side to accept or take ownership for behaviour and change it (S2-ST)

##### 5. *Control (identified by 71% of participants; 83 references total)*

The fifth theme was that of control. Control was defined as power to influence or direct people's behaviour or the course of events. As with responsibility, control ranged from excesses or insufficient control within the carer relationship. Excesses of control were attributed to originating from both ends of the relationship; that is, carers identified that both they and the care-receiver excessively used control. For example:

He can control every situation (S1-ST)

There's still that need to control things from his point of view, which is extremely frustrating for me and that's probably the root cause of a lot of our conflicts actually (S2-ST)

Me observing and over controlling, and stepping in (OR4-LT)

Carers also noted that control was insufficient- there was a lack of control or gaining control was 'hard to do'- within the carer relationship. Carers perceived that control being 'hard to do' originated from their end of the relationship, with examples as follows:

You don't have any control (P16-LT)

I feel like I don't have a say...I just feel like I have to back down (OR3-ST)

I know people say to me 'you let her' but if you... she is very difficult and she is abusive. It's hard. It's really hard (P2-ST)

Whilst carers self-identified as having insufficient control over aspects of their relationship, many attributed this to the care-receivers perceived defiance. Carers described the care-receiver as behaving oppositionally, which left them feeling powerless to take control within the relationship.

I thought 'it doesn't matter what I say or what I do, he's just gonna do what he wants anyway' (P16-LT)

He has been told that he shouldn't do it and that he must stop and it just continues (ON1-LT)

When reflecting on how control presented within the relationship, many carers self-identified that this is an area they wanted skills to help them manage. This presented regardless of which end of the spectrum control was identified at- the common element was a desire for control to 'balance out'.

I need to be able to say in a way that is not boom boom, direct and confronting. I need to be able to say to him in a softer way (P8-LT)

I just want to – how to get control over the conversation instead of being overpowering and overbearing of somebody (OR3-ST)

I need to create better boundaries (P17-LT)

6. *Communication (identified by 50% of participants; 53 references total)*

The sixth theme was communication. Communication was defined as the imparting or exchanging of information by speaking, writing, or another medium. Communication presented as an interpersonal problem as it existed as inadequate within the relationship between the carer and care-receiver.

Carers described finding it hard to communicate with the care-receiver, contributing to relational difficulties. This is illustrated by:

It really does feel uncomfortable not going with the flow where she's been at and not feeling comfortable enough in applying different ways of communicating with her (P3-ST)

It's like talking another language, and if you've only got one – if one of the words is the wrong word in that sentence it changes the whole meaning of the sentence (P13-LT)

Communication is non-existent (P10-LT)

Communication between the carer and care-receiver was confounded due to a lack of understanding in the relationship. Carers expressed feeling like they could not understand their loved one, and that the care-receiver communicated in a manner that also displayed a lack of understanding. This is illustrated by:

I'd like to try and understand more of where he's coming from (P16-LT)

I wanted her to understand my point of view (OR3-ST)

Whilst communication difficulties existed on both sides of the relationship, carers noted that a perceived inability/unwillingness to listen originated from the care-receiver. Examples include:

I want to be heard, I don't feel I'm heard, like very, very, very rarely am I ever heard in any interaction generally (S2-ST)

I would like him to take more notice of what I say (P13-LT)

*7. Role challenges (identified by 50% of participants; 38 references total)*

The final theme was role challenges, seen to be difficulties navigating the expected behaviour pattern associated with ones roles. A common challenge for carers was navigating their dual role as a carer to the care-receiver and a person in a relationship (i.e. parent, spouse, relative etc.) with the care-receiver. When discussing the difficulties in juggling these two roles, there was a sense that the carer role took prominence. Carers expressed feeling like they could not be a person in a relationship with the care-receiver (i.e. be a parent, a spouse, etc.), due to the demands to fulfil their role as a carer. This is evident in the following quotes:

I feel like I'm nearly 100% carer, I'm not – I don't really have a wife role at all (S2-ST)

I always feel like I'm a referee, an umpire and I think that cuts out a lot of intimacy because then I'm taking almost like a parent figure in that role (S3-ST)

I can't play both roles (P17-LT)

When reflecting on these role challenges, there was a sense of identity loss present for carers. Carers noted that they felt they could not be themselves within the relationship- or that who they were was not seen- due to the need to act as a 'carer'.

I can't be myself. I can't be me. I have to be what they want me to be (P2-ST)

I'm just that person, that caring person, enabling person (P3-ST)

Lastly, carers described difficulties in stepping back from their roles and focusing on their own needs as a person. The carer role was associated with meeting the needs of others, and the balance of the carers own needs being met within this relationship was overlooked.

I don't feel like I've got opportunity to have a life for myself or my needs met (P4-ST)

It's a hard balance between 'he needs me' but then 'so does everyone else' (OR4-LT)

## Discussion

Mental health caregiving is unpredictable and episodic and frequently generates "uncomfortable" thoughts and emotions in carers (A. Losada et al., 2015). This is most clearly reflected in the interpersonal problem of emotion management, with our study highlighting the prevalence of anger, anxiety and 'upset' in mental health carer relationships. These findings are consistent with that of previous literature- which indicates that carers experience these emotions, alongside a myriad of others such as resentment, isolation, fear, hopelessness, loss, guilt and denial (Albert & Simpson, 2015; Gray, Seddon, Robinson, & Roberts, 2009; Wynaden, 2007).

In the face of a lifecontext that can raise such difficult emotions, it is understandable that carers may make attempts to avoid stimuli that could evoke such experiences. Our study highlights that mental health carers experience avoidance as a significant interpersonal problem within their relationships. It is established that carers experience moderate to high levels of avoidance (Ulstein, Wyller, & Engedal, 2008), with indications that avoidance is utilised as a means of coping (van Teijlingen Edwin & Lowit, 2005). Ironically, though

intended as a means of reducing short term distress, avoidance has a negative impact on the long term coping of carers (Orsillo, Roemer, & Barlow, 2003). Avoidant process in carers are associated with symptoms of anxiety (Ulstein et al., 2008), distress (Onwumere et al., 2011) and depression (A. Losada et al., 2015). In the context of relationships, avoidant tendencies may result in a distancing of carers from their personal values (Orsillo et al., 2003); getting in the way of being the person they want to be in their caring relationship. There are established interventions for reducing experiential avoidance, though there remains a need to assess suitability for the mental health carer population. The progression of interventions in this area needs to identify which interpersonal experiences are being avoided (e.g., emotion management, aggression) in order to increase mental health carers capacity for those experiences. Furthermore, the impact of avoidance on interpersonal functioning needs to be considered- that is, does reducing avoidance correspond with an increase in the strength, quality, and functionality of the carer relationship?

Avoidance is often utilised when an individual perceives they lack control to effectively manage a situation, or misjudge which experiences are within their power to alter (Chawla & Ostafin, 2007; Hayes & Wilson, 1994). Consistent with our finding of control as an interpersonal problem, research has indicated that many carers perceive a lack of control in their lives and relationship with the care-receiver (Wilkinson & McAndrew, 2008; Williams, Dagnan, Rodgers, & Freeston, 2015). However, despite feeling like they lack control, carers often perceive themselves as holding responsibility for their loved ones (Harden, 2005; Hughes, Locock, & Ziebland, 2013; Penning & Zheng, 2016). In our findings, control and responsibility presented as a continuum, at which interpersonal problems existed at either end. This mirrors contemporary interpersonal theory, which assumes interpersonal behaviours can be described along two principal dimensions: affiliation, which ranges from hostile behaviour to friendly behaviour; and control, which ranges from submissive behaviour

to dominating behaviour (Alden et al., 1990; Horowitz et al., 2000). In our study, both ends of the 'control' dimension emerged (excesses and inhibitions of control and responsibility), whereas only the hostile end of the 'affiliation' dimension emerged (excesses of aggression).

The finding that mental health carers often experience high levels of hostility and aggression within their caring relationship is consistent with that of previous research. Hostile and critical interactions are characteristic of high expressed emotion; a widely researched experience within the caregiver population (Cherry, Taylor, Brown, Rigby, & Sellwood, 2017). The presence of aggression and hostility in carer relationships is associated with poorer relationships between carers and care-receivers (Spector, Charlesworth, Orrell, & Marston, 2016; N. Spruytte, Van Audenhove, Lammertyn, & Storms, 2002) and higher burden and distress for carers (González-Blanch et al., 2010). There are suggestions that carers may minimize the aggression experienced within their relationship, due to conflicting emotions of loyalty and betrayal (Albert & Simpson, 2015). The presence of aggression as an interpersonal problem for mental health carers, in the backdrop of the presence of avoidance, highlights the importance of considering mental health carer interpersonal problems in a holistic manner, rather than focusing on experiences in isolation. If the aim is for carers to manage difficult internal and external experiences (rather than avoid), this needs to occur in a contextually sensitive manner that targets the overall pattern of relating.

A relational context high in negative emotions and aggression does not provide an easy platform for healthy communication. Communication presented as an interpersonal problem in our findings, with carers noting there were difficulties in understanding each other, communicating needs and listening within the relationship. The mental health diagnosis of the care receiver would be a confounding factor here, with particular illnesses such as schizophrenia carrying with them more communication barriers (Bazin, Sarfati, Lefrère, Passerieux, & Hardy-Baylé, 2005; Best & Bowie, 2013). Communication is essential to

maintaining a person's health and wellbeing (Kyle, Melville, & Jones, 2010), and so the significance of supporting mental health carers to improve this interpersonal process is high.

The interpersonal problems that arose during this study overlap with other problems that have been identified amongst carers (e.g., expressed emotion) and there are a range of interventions to address these difficulties (e.g. Acceptance and Commitment Therapy for carer avoidance; Andrés Losada, Márquez-González, Romero-Moreno, & López, 2014). However, these specific relational difficulties are often considered in isolation, with the reduction of symptoms or problematic behaviours the goal of treatment rather than overall interpersonal functioning. This emphasises the need for comprehensive evaluation of interpersonal problems in mental health carers, using established measures such as the Inventory of Interpersonal Problems (Alden et al., 1990; Horowitz et al., 2000; Horowitz, Rosenberg, Baer, Ureno, & Villasenor, 1988). Such evaluation provides a direct connection between assessment, interpersonal theory and intervention; allowing treatment to be tailored to a mental health carers specific interpersonal problem profile. Interpersonal problems have been shown to predict the success of treatment and individual responses to therapy; providing a platform on which to base individualized treatment planning. For example, interpersonal problems related to coldness and avoidance benefit from graded exposure (Alden & Capreol, 1993) whereas individuals with interpersonal problems related to dominance and intrusiveness respond more favourably to experiential behaviour interventions (Newman, Jacobson, Erickson, & Fisher, 2017). However, in light of suggestions that 'change in [Australian carer] clinical practice will only occur if it is mandated by legislation, well grounded in policy and protocols' (McMahon, Hardy, & Carson, 2007, p.10), the need for evidence based treatment protocols and supporting policies is highlighted. Although Australian social policy has commenced recognising the importance of carer relationships

(Department of Human Services, 2006; Carers Recognition Act, 2010), there is still little guidance provided to the resources needed to support carers in this interpersonal role.

The current sample consisted of primarily female mental health carers and the majority were caring for a family member, and thus cannot be seen to be representative of mental health carers as a whole. The potential mediating influences of gender, care relationship to care-recipient, mental health diagnosis and length of caring role warrant further investigation. A strength of this study was the qualitative methodology, which allowed for the exploration of a topic area in which there has been little previous research. The combination of open narrative and semi-structured questions enabled rich data to be collected on mental health carers interpersonal problems, and identified areas for further exploration. Future research could adopt a quantitative methodology, utilising standardized measures of interpersonal problems. A limitation of the chosen methodology is the reliance on the views of mental health carers only. Considering carers and care-receivers experience disparity in how they view their relationship (Manne et al., 2006), this study could have been improved by involving both parties as active research participants.

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Table 1. *Demographic characteristics of sample*

Category		Frequency (%)
Sex		
Female		24 (86%)
Male		4 (14%)
Age		
26-50		12 (43%)
50+		16 (57%)
Relationship to care-receiver		
Parent		17 (60%)
Spouse		5 (18%)
Adult child	1 (4%)	
Other relative	4 (14%)	
Other non-relative	1 (4%)	
Length of time caring		
1-6 years	7 (25%)	
6-10 years	5 (18%)	
10+ years	16 (57%)	
Mental Health Condition of care-receiver (as identified by carer)	12 (43%)	
Anxiety	9 (32%)	
Depression		
Borderline personality disorder	6 (21%)	
Bipolar	5 (18%)	
Post-traumatic stress disorder	5 (18%)	
Schizo-affective	4 (14%)	
Drug induced psychosis	3 (11%)	
Obsessive compulsive disorder	2 (7%)	
Narcissistic personality disorder	1 (4%)	

*Note.* Frequency and percentages of mental health conditions greater than sample size (n=28) due to multiple diagnoses being able to be endorsed