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The effects of attachment and outness on illness adjustment among gay men with prostate cancer

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Abstract

Objective: Previous research has suggested that gay men facing prostate cancer may be particularly vulnerable to poor illness adjustment. Moreover, although attachment and greater disclosure of sexual orientation have been associated with health outcomes, their associations in this population have been largely unexamined. The purpose of the present study was to investigate whether greater outness about one's sexual orientation significantly mediated the associations between anxious and avoidant attachment and illness intrusiveness among gay men with prostate cancer.

Methods: 92 gay and bisexual men who had received a diagnosis of prostate cancer in the past four years were recruited for the present study. Self-report questionnaires assessed demographic and medical variables, attachment, outness level and comfort, and illness intrusiveness. Bootstrapping procedures were used to assess for mediation.

Results: Results suggested significant associations between anxious attachment, outness comfort, and illness intrusiveness. Less comfort with outness significantly mediated the association between greater anxious attachment and more illness intrusiveness. Avoidant attachment was not significantly associated with illness intrusiveness.

Conclusions: Findings support the mediating role of the subjective experience of being an out gay man in the association between anxious attachment and illness intrusiveness. These results suggest that facilitating greater comfort with outness would be beneficial for illness adjustment among gay men with prostate cancer whom have more anxious attachment styles.

Keywords

prostate cancer; gay men; outness; attachment; illness intrusiveness; psycho-oncology

Background

Prostate cancer (PCa) has been associated with impaired physical and psychological well-being [1]. Gay men with PCa appear to be particularly vulnerable to negative health outcomes [2]. In research on sexual orientation, being more “out” as a gay-identified

individual has been shown to have a beneficial effect on physical and mental health outcomes [3]. As disclosure of one's sexual orientation is an inherently interpersonal process, significant associations have been reported between less outness and greater anxious and avoidant attachment [4]. Greater anxious and avoidant attachment have been additionally predictive of poorer health outcomes [5]. Despite the significant utility of attachment styles and outness in understanding health outcomes, these constructs have not been examined among gay men with PCa, nor has previous research examined whether outness mediates the association between attachment and physical health outcomes. The present study seeks to fill these gaps in the literature by examining the extent to which outness mediates the association between anxious and avoidant attachment on illness intrusiveness among gay men with PCa.

PCa is the most common cancer among men and has 5-year survival rates of nearly 100%, highlighting the importance of a focus on quality of life and related variables. Studies have demonstrated impaired quality of life, greater psychological distress, and more physical symptoms among PCa patients compared to the general population [1]. Illness intrusiveness provides a measure of the extent to which cancer interferes with valued activities [6]. It is conceptualized as a fundamental determinant of physical well-being as it speaks to the disruption of meaningful activities and interests that compromise quality of life [7]. Illness intrusiveness has been associated with negative outcomes such as distress, depression, and health-related quality of life [8]. Although not extensively studied in this population, PCa patients appear to experience substantial levels of illness intrusiveness [2,6].

Despite the vast literature on men facing PCa, relatively few studies have examined the unique experience of gay men. Studies have largely identified greater vulnerability to negative health outcomes for sexual minorities within the cancer context. A study of gay men with PCa revealed significantly more urinary, bowel, and hormonal symptom bother, and greater sexual dysfunction, compared to population means [2]. In another study, compared to heterosexual men, nonheterosexual men reported higher Gleason scores (i.e., higher scores reflect more abnormal prostate cells and a higher likelihood of cancer spread) at diagnosis and greater ejaculatory bother [9]. Moreover, there is evidence that gay men experience significantly greater declines in sexual functioning with PCa treatment compared to heterosexual men [10]. This literature suggests that gay men may experience significantly greater severity and bother by physical symptoms, especially those affecting sexual functioning.

The literature has also highlighted distressing psychosocial concerns facing gay men with PCa [11]. Relative to heterosexual men, sexual minority men with cancer have reported greater depressive symptoms and relationship difficulties [12]. Qualitative studies have described concerns such as heteronormativity in the healthcare system (e.g., providers assuming the patient engages in only heterosexual sexual activity), lack of clarity of the role of gay men's intimate partners in their medical care, and difficulties relating to other gay men in the community after the effects of PCa treatment on their body [13]. Moreover, gay men have described a lack of understanding by healthcare professionals about the ways that they are differentially affected by sexual changes from PCa treatment. For example, assessment of erectile function frequently presumes vaginal and not anal penetration, which

requires greater erectile rigidity, and bowel problems and anal sensitivity may pose particular impairment [11]. This underscores the importance of understanding contributors to illness adjustment of gay men with PCa.

One of the important contributors to well-being among gay men includes outness, or greater disclosure about sexual orientation, which is an integral aspect of forming and embracing one's identity [14]. Outness has been operationalized in previous studies as including a dichotomized disclosed versus non-disclosure measure [15] and a 5-point measure of broad concealment of outness ranging from "definitely in the closet" to "completely out of the closet" [3]. In sexual minority populations, openness about one's sexual identity has demonstrated positive effects on emotional and physical well-being [3,15]. For example, HIV positive men who concealed their sexual identity were shown to have greater HIV progression over a period of 6-months compared to men who did not conceal their identity [3]. Additionally, outness predicted regular health care use among lesbian and bisexual women in a primary healthcare setting [16]. Despite the literature supporting the beneficial effects of outness, its association with health outcomes among gay men with PCa has not been examined. Moreover, number of people knowing an individual is gay is not equivalent to assuming that an individual is comfortable with being out. An individual may have been forced out of the closet or is gender non-conforming and subsequently a target for harassment. Research is needed that examines level as well as comfort with outness.

Disclosure of sexual identity is an inherently interpersonal process; further, it is a process that involves revealing a stigmatized identity, risking rejection and social isolation, while seeking connection within the gay community. Consistent with the milieu of disclosure of sexual orientation, greater anxious and avoidant attachment have been associated with less outness [4]. Attachment refers to internal working models or mental representations of relationships internalized from early interactions with primary caregivers. Attachment is conceptualized as a multidimensional construct comprised of cognitions such as beliefs about the nature of relationships and expectations of significant others, behaviours such as the viability to support seeking and behavioural interactions approaching and within relationships, and affect such as emotional reactivity and emotion regulation [17]. Two orthogonal attachment dimensions have been posited, that of avoidant and anxious attachment [18]. Greater anxious attachment refers to a tendency towards anxiety about rejection and abandonment, as individuals tend to believe they are not worthy of love and support. Greater avoidant attachment refers to a tendency to avoid relationships and discomfort with intimacy and dependence, as individuals tend to believe that others are not reliable or trustworthy [18]. Although some research supports the role of attachment as an individual difference variable, consistent across situations and relationships, suggesting its role as a general personality variable, other research has demonstrated its variability across different attachment figures, suggesting individuals hold general and specific internal working models [19].

Greater outness or disclosure of sexual orientation has been associated with less anxious and avoidant attachment [4,14]. Jellison and McConnell reported that individuals who were less anxiously or avoidantly attached held less negative views about their sexual orientation, which led to greater disclosure [4]. Studies have additionally reported a negative relationship

between avoidant attachment and outness, but not anxious attachment [14]. It has been suggested that as individuals with greater avoidant attachment hold a more negative view of others, they are unlikely to believe that others will respond in a trustworthy and accepting manner [14]. Moreover, self-disclosure of any kind, as a process that enhances intimacy, has been negatively associated with avoidant attachment [20].

Greater anxious or avoidant attachment has also been associated with more impaired physical health [5]. It has been linked with exacerbated physical symptoms in cancer populations [21]. It has additionally been associated with more impaired quality of life [22] and poorer psychosocial adjustment in cancer populations [23]. A single study on attachment within the literature on PCa reported that more avoidant attachment predicted less frequent PCa screening [24]. Although attachment has been associated with negative health outcomes, the relationship between attachment and illness intrusiveness has never been examined.

The few studies that have examined the unique experience of gay men with PCa have highlighted the importance of understanding contributors to illness adjustment, as gay men appear to experience significantly worse quality of life and greater symptom bother than their heterosexual counterparts [2]. Although outness has been identified as contributing to well-being in the greater literature, its association with illness adjustment among cancer patients has not been investigated. Moreover, given the interpersonal nature of disclosure of sexual orientation, outness may help explain the association between attachment and health outcomes. The present study seeks to examine the relationships between attachment, outness, and illness intrusiveness among gay men with prostate cancer. It is expected that less outness will mediate the relationship between more anxious and avoidant attachment and greater illness intrusiveness.

Methods

Participants and procedures

Approval for this study was obtained from the Institutional Review Boards at Ryerson University in Toronto and at Baylor College of Medicine in Houston. Eligible participants were adult males who self-identified as gay or bisexual and had received a diagnosis of PCa in the past four years. The short post-diagnosis window was chosen to recruit participants who were diagnosed more recently and would be able to more accurately recall their treatment experiences. Participants were recruited by advertising in the community, including emailing list serves, posting flyers, posting messages on online forums, reaching out to support groups, and advertising in the local media. Flyers were mailed to each gay and lesbian community organization that could be identified in the US through internet searches. Recruitment materials were targeted at men who specifically identified as gay or bisexual.

Interested participants were invited to call a toll-free phone number. A brief screening interview was conducted to ensure eligibility, after which verbal consent was obtained. Eligible participants were emailed a link to a web-based survey as well as a personal, confidential study identification code to enter into the survey. Names and other identifying information were not collected online. All identifying information was kept in a secure,

protected location. The survey took approximately one hour to complete, and participants received \$20 for survey completion.

Measures

Demographic and medical information.—Background information about demographics (age, education, ethnicity, occupation, and income) and medical information (time since diagnosis, stage at diagnosis, and treatment type) were assessed via self-report. These questions mirrored that of a large-scale PCa outcome study [25].

Attachment.—Adult attachment was assessed using the Relationship Questionnaire (RQ) [17]. This measure consists of a forced choice paradigm between four short paragraphs describing each attachment style, followed by continuous ratings of the degree of correspondence with each attachment prototype. Participants were asked to rate the extent to which each description corresponds to their general relationship style on a scale from “1 – Not at all like me” to “7 – Very much like me”. The continuous ratings were then used to derive two attachment dimensions: anxious and avoidant attachment. Higher scores on each dimension reflect greater anxious and avoidant attachment. The RQ has been demonstrated to have adequate reliability and validity, and it has been suggested that the RQ is especially useful in research with health populations [26].

Illness intrusiveness.—The extent to which PCa interferes with valued life activities was assessed with the Illness Intrusiveness Rating Scale [7]. Participants were asked to rate the extent to which their illness and treatment has interfered with a 13-item list of varying life domains such as recreational activities, work, and intimate relationships, on a Likert scale ranging from “1 – Not very much” to “7 – Very much”. This measure has demonstrated high internal reliability and strong validity [7]. The scale demonstrated strong reliability with Cronbach’s alpha of .92.

Disclosure of sexual orientation.—Extent of disclosure about one’s sexual orientation or “outness” was assessed with 10-items developed for the present study, modeled after the Outness Inventory [27]. As with the Outness Inventory, participants were asked to rate on a 7-point Likert scale, the extent to which they were “out” to people in five different roles in their lives (family, heterosexual friends, work peers, supervisors, and strangers) from “1 – Definitely do not know about your sexual orientation status” to “7 – Definitely do know about your sexual orientation status and it is talked about.” These items generated the outness level subscale. Participants were also asked for each of those individuals, how comfortable the participant is with their level of outness to each person from “1 – Very uncomfortable” to “7 – Very comfortable” to generate the outness comfort subscale. Outness level and outness comfort subscales had strong reliability in the present sample with Cronbach’s alpha of .89 and .86 respectively.

Data analysis

To examine the degree to which outness mediated the association between attachment and illness intrusiveness, a bootstrapping procedure was used. Bootstrapping is the most highly recommended current test for mediation [28]. It involves repeatedly, randomly sampling the

data with replacement. The INDIRECT macro was used to obtain bootstrap estimates and bias-corrected confidence intervals. For the present study, observations were resampled 10,000 times to provide an approximate representation of the sampling distribution of the statistic of interest in the original population [29]. A 95% confidence interval was obtained, which represents the upper and lower confidence limits of the parameter. If the confidence interval does not pass through zero, then it is estimated with 95% confidence that the parameter is significantly different from zero, and an indirect effect exists [29]. An indirect effect signifies that there is a relationship between the predictor, the mediator, and the outcome variable when they are tested as a model. On the other hand, mediation occurs when zero is outside the confidence interval and there is a significant direct relationship between the predictor and the outcome variable.

For the present study, four mediation models were tested, examining the effect of each attachment dimension on the outcome variable of illness intrusiveness through the mediator of each of outness level and outness comfort. Days since diagnosis and age were controlled for in each analysis.

Results

Participant demographics and descriptive information

The sample consisted of 92 men. Demographic and medical information is displayed in Table 1. Mean age was 57.8 years. The majority of participants were Caucasian, highly educated, employed full- or part-time, and in a relationship. Majority of the sample, approximately 90%, had low-grade disease of Gleason 6 or less at diagnosis. Average time since diagnosis was 1.91 years. Treatments included radical prostatectomy (55.4%), external radiation (27.2%), hormone therapy (25%), and active surveillance (8.7%). The type of treatment percentages add up to more than 100% because some men had more than one treatment. Table 1 further demonstrates the means and standard deviations of anxious and avoidant attachment, outness level and comfort, and illness intrusiveness. Participants appeared to endorse a moderate level of illness intrusiveness, reporting a mean of 30.93, slightly more severe than another sample of men with prostate cancer who endorsed a mean total of 28.56 [6].

Preliminary Analyses: Correlations between study variables

The correlations between demographic and medical covariates and the primary study variables are displayed in Table 2. There was a significant, negative correlation between illness intrusiveness and age and days since diagnosis, such that greater illness intrusiveness was associated with younger age and fewer days since diagnosis. Age and days since diagnosis, were included as covariates in the mediation analyses.

Illness intrusiveness was significantly positively associated with anxious but not avoidant attachment. That is, greater illness intrusiveness was associated with greater anxious attachment. As mediation may take place without a direct effect between attachment and illness intrusiveness, analyses still examined the indirect effects for avoidant attachment. Finally, there was a significant negative association between illness intrusiveness and

outness comfort and a non-significant association with outness level. That is, greater illness intrusiveness was significantly associated with less outness comfort.

Mediation analyses

The results of the mediation analyses with outness comfort as a mediator are displayed in Table 3. For mediation model 1, anxious attachment had a significant, negative effect on outness comfort, such that greater anxious attachment was associated with less outness comfort. Anxious attachment also had a significant, positive effect on illness intrusiveness such that greater anxious attachment was associated with greater illness intrusiveness. Outness comfort had a significant, negative effect on illness intrusiveness, such that greater outness comfort was associated with less illness intrusiveness. For mediation model 2, avoidant attachment did not have a significant effect on outness comfort or illness intrusiveness. Again, outness comfort had a significant, negative effect on illness intrusiveness.

The 95% confidence interval confirmed that greater outness comfort significantly mediated the association between greater anxious attachment and more illness intrusiveness, bootstrap estimate=0.43, SE=0.23, CI=0.05 – 0.96. The total model had an adjusted $R^2=0.25$, $F=7.68$, $p<0.001$. Therefore, 25% of the variance in illness intrusiveness was accounted for by the variables in this model. The 95% confidence interval failed to demonstrate a significant indirect effect for the model including the variables avoidant attachment, outness comfort, and illness intrusiveness, bootstrap estimate=0.20, SE=0.17, CI=-0.48–0.65.

Consistent with preliminary analyses, mediation analyses confirmed that outness level did not significantly mediate the association between anxious attachment and illness intrusiveness, bootstrap estimate=0.09, SE=0.12, CI=-0.08–0.45. Outness level additionally did not mediate the association between avoidant attachment and illness intrusiveness, bootstrap estimate=0.05, SE=0.09, CI=-0.06–0.35.

Conclusions

The present study examined the associations between attachment, outness, and illness intrusiveness for the first time in a sample of gay men with PCa. The results demonstrated significant negative associations between (1) comfort with being out and illness intrusiveness and (2) anxious attachment and comfort with being out, and a significant positive association between (3) anxious attachment and illness intrusiveness. Furthermore, less comfort with being out significantly mediated the association between greater anxious attachment and more illness intrusiveness.

The finding that attachment anxiety, and not avoidance, was associated with illness intrusiveness is consistent with the mixed literature regarding avoidant attachment and health outcomes [30]. It is also consistent with attachment theory which suggests that individuals higher in avoidant attachment make use of deactivating strategies, behaviours aimed at inhibiting the need for support seeking, such as minimizing distress, while individuals higher in anxious attachment employ hyperactivating strategies, behaviours aimed at eliciting supportive responses from others perceived to be unresponsive, such as intensified signals of

distress [30]. Indeed, in a study of healthy adults, individuals higher in anxious attachment reported greater subjective and physiological stress compared to those whose endorsed less attachment anxiety in response to a stress induction protocol, while avoidant attachment was unrelated to subjective stress but was positively associated with physiological measures of stress [31].

Moreover, attachment theory posits that the attachment system is activated in periods of stress, suggesting that the hyperactivating and deactivating strategies of those more anxiously and avoidantly attached may be particularly relevant among those facing cancer. In fact, the presence of cancer has been shown to significantly moderate the effect of attachment on health outcomes, demonstrating a significantly stronger relationship between anxious and avoidant attachment and negative health outcomes for individuals with cancer compared to healthy controls [22]. Greater time since diagnosis may result in less of a trigger for attachment as with more time stress level goes down, as does the illness intrusiveness [32].

Our data show that being less comfortable with disclosure of one's sexual orientation significantly accounts, at least in part, for the effects of a more anxious type of attachment on the intrusiveness of illness symptoms on valued activities. Individuals with greater anxious attachment tend to fear and be hypervigilant towards interpersonal rejection and report less trust in their relationships [33]. Moreover, anxious attachment appears to have a stronger effect on avoidant goals, such as avoidance of rejection, than approach goals, such as enhancing intimacy [34]. This attendance towards relational threats among those with greater anxious attachment may result in less comfort with being out for fear of rejection or abandonment.

Less comfort with outness is subsequently associated with greater illness intrusiveness, which is consistent with the Disclosure Process Model [35]. This model suggests mediating processes that account for the beneficial effects of disclosure including alleviation of the psychological and physiological burden of concealment, allowance of individuals to garner greater social support, and changes in the ways individuals interact with their environment and receive social information [35]. Indeed, the literature on sexual minority individuals with cancer has emphasized the importance of support by partners in cancer care and treatment-related decisions [36]; greater outness to the world at large may facilitate greater social support in general as well as greater inclusion of significant others within the process of coping with cancer. Additionally, being more out may facilitate better communication with healthcare providers about the consequences of PCa, allowing for greater provision of relevant symptom management information and more clinician-patient agreement [37]. A personal account of a gay man facing PCa emphasized the importance of the patient truly understanding his treatment options and sexual side effects to be informed and empowered to make the right choice for himself [38].

Surprisingly, while attachment and illness intrusiveness were associated with outness comfort, there was a non-significant relationship with outness level. This is unexpected given the research supporting these associations [3,14]. However, in contrast to these previous studies, the present research examined extent of outness to various people.

Additionally, our data may have been limited by lack of variability of outness level in the present sample. As this study was advertised seeking gay and bisexual men, and much of the advertising and outreach was in gay communities and forums, it is reasonable to expect that the participants may be more out than the average population. Nonetheless, the results of the present study support that how an individual feels about being out, or one's subjective appraisal of being out, is more important in understanding the association between attachment and illness intrusiveness than level of outness. For example, if an individual is uncomfortable being out, he may not be actively participating in the gay community and thus not benefitting from this important source of support. Alternatively if an individual is comfortable with being out as a gay man, he may be more able to advocate for his unique needs, make use of support networks, and seek out information. However, further research may be needed to continue to understand the unique effects of outness comfort and outness level in the illness experience of gay men with PCa.

Our findings are limited by the cross-sectional design and the predominantly early-stage prostate cancer, Caucasian, and highly educated sample. Additionally, attachment was operationalized with the RQ. The internal reliability of the RQ has been shown to vary from low to high and low to moderate stability has been reported over time [26]. However, it has been suggested that the brevity and structure of the RQ makes it ideally suited for use in medical settings [26]. Additionally, the RQ was chosen because of the large number of studies that showed significant associations between health outcomes and attachment as operationalized with this measure [39]. We are also missing information on a number of variables that would help to characterize our sample, for example, whether men identified as either gay or as bisexual, and how specifically they were recruited into the study (e.g., support groups, gay listserves). This information could have helped to further contextualize our findings on outness level and outness comfort. In addition, all prostate cancer diagnostic information (i.e., Gleason scores) and treatment information was obtained via self-report. One-third of men did not report their Gleason scores, so it is possible that the mean level is underestimated for the sample. Moreover, we did not obtain data about prostate cancer recurrence or about temporal sequence of treatment, so information about the experience of men diagnosed with localized disease who then progressed to advanced disease for at least some of the participants is missing. Finally, the findings are limited by lack of information about outness to healthcare providers in particular; future studies should consider including this information.

Despite these limitations, the implications of the present study suggest that greater comfort with outness serves a protective function toward illness adjustment. Attachment has been shown to be quite stable over time [19] and therefore may not be the most efficient mechanism of change; the results of the present study suggest a mechanism of action through the mediator of outness comfort, which may alleviate some of the illness burden experienced. For example, although healthcare providers may not be privy to information about their patient's sexual orientation, greater sensitivity by healthcare providers by avoiding heteronormative assumptions could aid in more comfort for gay men with PCa. Moreover, if it is known that a patient is gay, greater healthcare provider awareness of the unique effects of physical side effects on gay men [2] may put patients at ease and allow for more open communication about illness intrusiveness and allow for more helpful symptom

management. Although the literature has not identified specific psychological interventions that improve outness comfort per se, psycho-oncologists should consider whether illness adjustment among gay men with PCa can be improved by interventions that address internalized homonegativity and minority stress [40]. Future research should examine whether similar cognitive, behavioural, and affective pathways that influence minority stress, such as validating and reframing negative cognitions from past and ongoing minority stress experiences [40], can be similarly used by psycho-oncologists to improve outness comfort and illness intrusiveness among gay men with PCa.

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Table 1.

Participant characteristics and key variables. SD = standard deviation.

	N	Mean (SD)
Age	89	57.8 (9.2)
Months since diagnosis	86	23.3 (16.9)
PSA level	75	8.7 (9.6)
Gleason Score		%
1 – 6	55	90.2
7+	6	9.8
Relationship status		
Married/living with partner	42	45.7
Primary partner, not cohabitating	16	17.4
No primary partner	21	22.8
Dating one or more people	6	6.5
Separated or divorced	2	2.2
Widowed	3	3.3
Education		
High school degree	5	5.4
Some college	20	21.7
College/university	27	29.3
Graduate school	37	40.2
Ethnicity		
African American	5	5.4
Asian	1	1.1
Caucasian	84	91.3
Other	2	2.2
Work status		
Working full-time	30	32.6
Working part-time due to health	4	4.3
Working part-time not due to health	11	12.0
On leave	2	2.2
Temporarily laid-off or Unemployed	3	3.3
Disability/unable to work	4	4.3
Retired	26	28.3
Treatment		
Prostatectomy	51	55.4
External radiation	25	27.2
Brachytherapy	7	7.6
Hormone therapy	23	25.0
No treatment	8	8.7
		Mean (SD)
Anxious attachment	86	–.94 (4.3)

	N	Mean (SD)
Avoidant attachment	86	-.62 (4.6)
Outness level	90	69.53 (25.7)
Outness comfort	90	78.67 (21.9)
Illness intrusiveness	90	30.93 (19.92)

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Table 2.

Correlations between key study variables.

1. Age	2. Time since diagnosis	3. Anxious attachment	4. Avoidant attachment	5. Outness level	6. Outness comfort	7. Illness intrusiveness
1	-	.20	-.14	-.05	.11	.20
2		-	.07	-.19	.01	.18
3			-	.28**	-.22*	-.37***
4				-.08	-.18	.22
5				-	.63***	-.17
6					-	-.41***

* <.05
** <.01
*** <.001.

Table 3.

Bootstrapping analyses examining whether outness comfort mediates the association between attachment and illness intrusiveness.

Variables	B	SE	t	p
Mediation Model 1				
Anxious attachment → Outness comfort	−1.87	.53	−3.55	<.001
Anxious attachment → Illness intrusiveness	1.38	.45	3.08	.003
Outness comfort → Illness intrusiveness	−.23	.09	−2.46	.02
Mediation Model 2				
Avoidant attachment → Outness comfort	−.67	.54	−1.25	.22
Avoidant attachment → Illness intrusiveness	.68	.45	1.52	.13
Outness comfort → Illness intrusiveness	−.29	.09	−3.21	.002
Indirect Effects				
	Estimate	SE	LL 95% CI	UL 95% CI
Mediation model 1	.43	.23	.09	1.04
Mediation model 2	.20	.17	−.05	.65