

# The Brief Experiential Avoidance Questionnaire: Development and Initial Validation

Wakiza Gámez  
University of Iowa

Michael Chmielewski  
Southern Methodist University

Roman Kotov  
Stony Brook University

Camilo Ruggero  
University of North Texas

Nadia Suzuki and David Watson  
University of Notre Dame

The 62-item Multidimensional Experiential Avoidance Questionnaire (MEAQ) was recently developed to assess a broad range of experiential avoidance (EA) content. However, practical clinical and research considerations made a briefer measure of EA desirable. Using items from the original 62-item MEAQ, a 15-item scale was created that tapped content from each of the MEAQ's six dimensions. Items were selected on the basis of their performance in 3 samples: undergraduates ( $n = 363$ ), psychiatric outpatients ( $n = 265$ ), and community adults ( $n = 215$ ). These items were then evaluated using 2 additional samples (314 undergraduates and 201 psychiatric outpatients) and cross-validated in 2 new, independent samples (283 undergraduates and 295 community adults). The resulting measure (Brief Experiential Avoidance Questionnaire; BEAQ) demonstrated good internal consistency. It also exhibited strong convergence with respect to each of the MEAQ's 6 dimensions. The BEAQ demonstrated expected associations with measures of avoidance, psychopathology, and quality of life and was distinguishable from negative affectivity and neuroticism.

**Keywords:** experiential avoidance, avoidance, psychological flexibility, assessment, Multidimensional Experiential Avoidance Questionnaire

Experiential avoidance (EA) has been defined as an unwillingness to remain in contact with distressing emotions, thoughts, memories, and physical sensations, even when doing so creates harm in the long run (Hayes, Strosahl, & Wilson, 2012). It is a functional process that has been linked to a wide range of psychopathology, spanning the depressive, anxiety, and externalizing disorders (Chawla & Ostafin, 2007; Hayes, Wilson, Gifford, Follette, & Strosahl, 1996). Many seemingly unrelated manifestations of psychopathology (e.g., emotional distancing, isolation, compulsive rituals, bingeing and purging, substance abuse, self-harm, suicide) can be seen to share a common function of attempting to avoid distress in the short run. The concept of EA has antecedents in psychodynamic, experiential, behavioral, and cognitive approaches (see Hayes et al., 1996) and has been highlighted as a

central target of change in more recent third-wave cognitive behavior therapy approaches such as acceptance and commitment therapy (Hayes et al., 2012), dialectical behavior therapy (Linehan, 1993), functional analytic psychotherapy (Kohlenberg & Tsai, 2007), and behavioral activation (Martell, Addis, & Jacobson, 2001). Crucially, the concept of EA has marked a shift toward conceptualizing psychopathology in terms of an individual's behavioral responses to distress (avoidance) rather than the content of the distress itself (e.g., negative cognitions, upsetting feelings).

## Assessment of EA

Measurement of this core construct has largely focused on self-report questionnaires that tap narrowly defined yet related constructs such as thought suppression (Wegner & Zanakos, 1994), alexithymia (Bagby, Parker, & Taylor, 1994), distress tolerance (Simons & Gaher, 2005), or avoidant coping (Carver, Scheier, & Weintraub, 1989). The Acceptance and Action Questionnaire (AAQ; Bond & Bunce, 2003; Hayes et al., 2004) was the first measure created specifically to assess EA, but it produced inadequate estimates of reliability and internal consistency (Bond et al., 2011). The target of measurement was also redefined to encompass *psychological flexibility*, which includes aspects of EA as well as other concepts such as mindfulness, acceptance, and commitment to values (Hayes et al., 2012). The second version of the AAQ (AAQ-II; Bond et al., 2011) has resolved the problem of

---

This article was published Online First September 23, 2013.

Wakiza Gámez, Department of Psychology, University of Iowa; Michael Chmielewski, Department of Psychology, Southern Methodist University; Roman Kotov, Department of Psychiatry and Behavioral Science, Stony Brook University; Camilo Ruggero, Department of Psychology, University of North Texas; Nadia Suzuki and David Watson, Department of Psychology, University of Notre Dame.

Correspondence concerning this article should be addressed to Wakiza Gámez, Department of Psychology, University of Iowa, E11 Seashore Hall, Iowa City, IA 52242. E-mail: wakizagamez@gmail.com

weak internal consistency but exhibits poor discriminant associations vis-à-vis negative emotionality, particularly in patient samples. For example, the AAQ-II correlates more highly with measures of neuroticism and negative affectivity than it does with the AAQ and other measures of avoidance (Gámez, Chmielewski, Kotov, Ruggero, & Watson, 2011). This is reflected in the item content, which focuses on failed attempts at controlling distress (e.g., "emotions cause problems in my life"; "worries get in the way of my success") and nonspecific dysfunction (e.g., "it seems like most people are handling their lives better than I am").

The Multidimensional Experiential Avoidance Questionnaire (MEAQ; Gámez et al., 2011) was designed to address these issues: It covers a wide range of the broad EA construct with six subscales, and it exhibits both good internal consistency and good discrimination from negative emotionality (Gámez et al., 2011). Although the MEAQ offers improved assessment of EA, its length (62 items) might be prohibitive in certain clinical or research settings. An efficient instrument is needed for situations that do not require a multidimensional assessment of EA and in which only a brief measure can be administered because of logistical or practical constraints.

### Aims

Our goal was to develop a brief measure of EA (10–15 items) that (a) taps the same broad range of content as the 62-item MEAQ, (b) demonstrates good internal consistency across multiple populations, and (c) can be discriminated from negative emotionality. The MEAQ was administered to three samples (students, patients, and community adults) to help determine which items to include in the briefer measure. We then administered the selected items, embedded within the full MEAQ, to two additional samples (students and patients) to reevaluate internal consistency and to examine additional evidence of construct validity. Finally, the reduced 15-item measure (the Brief Experiential Avoidance Questionnaire; BEAQ) was administered independently from the MEAQ items and cross-validated in two new, independent samples (students and community adults).

### Phase 1 Method

#### Participants

A student sample ( $n = 363$ ) was recruited from a large public Southern university using a voluntary Internet-based sign-up system. Students were recruited from introductory psychology courses and completed questionnaires online using SurveyMonkey. Students received research credit for their participation; this counted toward the fulfillment of their course research exposure requirement. All students were given the option of writing an essay in lieu of participating in the study. The sample was 75% female, 64% Caucasian, 14% African American, 7% Asian American, and 15% mixed or other race. Ages ranged from 18 to 62 years ( $M = 20.48$  years,  $SD = 3.78$ ).

A patient sample ( $n = 265$ ) was recruited from various outpatient clinics in the Northeast (including an outpatient clinic of an academic psychiatry department, a clinic of a psychology department, a community mental health clinic, and two private clinics) to participate in a larger study examining personality and neural

profiles of mental disorders. Participants completed the MEAQ as well as an extensive battery of personality measures, psychophysiological measures, and interviews assessing symptoms and diagnoses of common mental disorders. Total length of the session was 5 hr. Patients were compensated monetarily for their time. Forty-four percent of patients met criteria for current major depressive disorder. Other prevalent disorders included specific phobia (32%), generalized anxiety disorder (26%), and social phobia (25%). Diagnoses were determined via the Structured Clinical Interview for *DSM-IV-TR* (SCID; First, Spitzer, Gibbon, & Williams, 2002). The sample was 59% female, 82% Caucasian, 9% African American, 4% mixed or other race, and 1% Asian American. Four percent identified as Hispanic or Latino. Their ages ranged from 18 to 79 years ( $M = 42.88$  years,  $SD = 13.59$ ).

A community sample ( $n = 215$ ) was recruited through an advertisement placed in a newsletter available to employees and visitors at a large Midwestern hospital. Approximately 2,000 of these hospital news and announcement flyers are printed daily and distributed 5 days/week. Individuals were encouraged to contact us (via phone or e-mail) for additional information. Interested participants were e-mailed a link to WebSurveyor, completed the questionnaire online, and were paid for their participation. The sample was 73% female, 95% Caucasian, and 5% Asian American. Three percent identified as Hispanic or Latino. Their ages ranged from 24 to 67 years ( $M = 38.18$  years,  $SD = 11.20$ ).

The three samples used for the Phase 1 analyses were reported previously in the original MEAQ scale development article (see Gámez et al., 2011).

### Measure

**MEAQ (Gámez et al., 2011).** The MEAQ is a 62-item measure of experiential avoidance that comprises six subscales: Behavioral Avoidance (situational avoidance of physical discomfort and distress), Distress Aversion (nonacceptance of or negative attitudes toward distress), Procrastination (delaying activities that may cause distress), Distraction/Suppression (attempts to ignore or suppress distress), Repression/Denial (distancing and dissociating from distress), and Distress Endurance (willingness to engage in behavior that is consistent with one's values even when in distress). Items are rated on a 6-point scale ranging from 1 (*strongly disagree*) to 6 (*strongly agree*). The subscales show evidence of good internal consistency, and the total score is both (a) associated with related measures of avoidance and (b) distinguishable from negative emotionality (Gámez et al., 2011).

### Item Selection

Items were selected on the basis of their loadings on a single common factor via exploratory factor analysis (EFA) conducted separately in each of the three samples. Consideration was given to those items that exhibited the most consistent loadings ( $>1.40$ ) on the single underlying factor among all 62 items across the three samples. Consideration also was given to assessing the broadest range of content possible (i.e., attempting to include items from each of the six MEAQ subscales). This method ensured that the resulting scale would exhibit good internal consistency and would be robust across populations while also providing adequate construct coverage. We included the items that displayed the top 20

highest loadings on the single factor; one exception was made for the highest loading Distress Endurance item (mean single-factor loading across samples = 1.40), which did not load in the top 20 but was retained in service of representative content coverage. We were able to achieve an adequate level of internal consistency ( $\alpha > .80$ ) with only 15 items and, therefore, dropped the other five top markers in the service of limiting scale length. Removing more than five items reduced alpha to  $< .80$  in the patient sample. We used the goal of broad representation of MEAQ content in determining which five items to drop. Consequently, four of the five items were from the Behavioral Avoidance subscale and one was from the Distress Aversion subscale—each of the items were the weakest loading items on the single factor from their respective subscale—as they were overrepresented in the top 20 (eight items from the former and five from the latter). This enabled us to retain high-loading items from other scales while maintaining sufficient representation of Behavioral Avoidance and Distress Aversion (four items apiece).

**Content coverage.** The resulting 15 items (the BEAQ) assess the avoidance of pain, uneasiness, effort, upset, unpleasantness, discomfort, emotions, painful emotions, feelings, bad feelings, upsetting feelings, fear/anxiety, unpleasant memories, and doubts (see the Appendix for the specific items). Eight items refer to explicit avoidance behavior (taken from the MEAQ Behavioral Avoidance, Distraction/Suppression, and Procrastination subscales), four items refer to attitudes/beliefs regarding distress (taken from the MEAQ Distress Aversion subscale), two items refer to implicit avoidance (taken from the MEAQ Repression/Denial subscale), and one item refers to the ability to respond effectively to distress (taken from the MEAQ Distress Endurance subscale). Taken together, these items cover much of the content that the MEAQ was originally designed to capture (see Gámez et al., 2011).

## Phase 1 Results

### Descriptive Statistics

Table 1 displays the scale means and standard deviations across the three Phase 1 samples. In general, it was expected that students would exhibit higher levels of EA relative to community adults given the elevated rates of psychopathology, distress, and neuroticism in this age group (see Costa & McCrae, 1992; Substance Abuse and Mental Health Services Administration, 2011) and that patients would report the highest rates of EA. Mean effect size

comparisons (Cohen's  $d$ ) were moderate to large—student versus community  $d = 0.41$ ,  $t = 4.81$ ,  $p < .001$ ; patient versus student  $d = 0.69$ ,  $t = 8.50$ ,  $p < .001$ ; patient versus community  $d = 1.04$ ,  $t = 11.33$ ,  $p < .001$ —indicating that the BEAQ is sensitive to population differences in EA.

### Internal Consistency

Internal consistency statistics for the Phase 1 samples are also reported in Table 1. These results (mean  $\alpha = .86$ , mean average interitem correlation [AIC] = .30) suggest adequate internal consistency (Clark & Watson, 1995; Nunnally, 1978) and reflect the fact that items were chosen, in part, for their ability to increase internal consistency. Another indication of how well these items hang together as representatives of a single overarching construct can be illustrated via factor analysis. Examination of the unrotated eigenvalues via scree plot suggested that a single general factor best described the data: The first five eigenvalues for each sample were 4.35, 1.43, 1.35, 1.07, and 0.94 for patients; 5.08, 1.39, 1.21, 1.19, and 0.86 for students; and 6.04, 1.44, 1.16, 0.92, and 0.83 for community adults. Table 2 displays the results of a single-factor EFA conducted on the BEAQ items. The percentage of variance explained was 28.98% for patients, 33.87% for students, and 40.28% for community adults. The range of loadings 1.33–.761 suggests homogeneity of the scale (Clark & Watson, 1995), with mean loadings of 1.441, 1.481, and 1.551 for patients, students, and community adults, respectively.

### Association With the MEAQ

Table 3 displays the correlations between the BEAQ and the MEAQ subscales across the three Phase 1 samples. The BEAQ shows moderate to high correlations with each of the six individual MEAQ subscales, suggesting that it is covering a sizable portion of the wide-ranging content from the longer measure. The Behavioral Avoidance and Distress Aversion subscales are the MEAQ subscales most strongly related to the BEAQ (mean  $r = .80$ ), whereas the Distress Endurance subscale tends to be less related (mean  $r = -.39$ ) relative to the other scales. The pattern of moderate to strong correlations reflects both the number of overlapping items from these scales and the centrality of these dimensions to the overarching EA construct (see Gámez et al., 2011). It should be noted that correlations between the BEAQ and the MEAQ subscales will be artifactually inflated because of the presence of overlapping items (see G. T. Smith, McCarthy, & Anderson, 2000).

Table 1  
Descriptive Statistics of the Brief Experiential Avoidance Questionnaire (BEAQ)

Statistic	Phase I			Phase II		Phase III	
	Patient	Student	Community	Patient	Student	Student	Community
<i>N</i>	265	363	215	201	314	283	295
<i>M</i>	56.41	48.22	43.33	52.03	43.72	47.73	49.37
<i>SD</i>	12.64	11.37	12.50	12.23	9.75	11.42	11.06
$\alpha$	.83	.86	.89	.83	.80	.85	.86
AIC	.25	.29	.35	.24	.21	.27	.29

Note. Phase I = scale development samples; Phase II = scale evaluation samples; Phase III = BEAQ cross-validation samples; AIC = average interitem correlation.

Table 2

Single Factor Loadings of Brief Experiential Avoidance Questionnaire (BEAQ) Items Across Seven Samples

Paraphrased item content	Phase I			Phase II		Phase III	
	P	S	C	P	S	S	C
Key to a good life is never feeling any pain	.57	.59	.58	.47	.52	.36	.60
Quick to leave situations that make me uneasy	.59	.59	.74	.66	.45	.52	.55
Try to put unpleasant memories out of mind	.46	.38	.46	.41	.50	.50	.31
Feel disconnected from my emotions	.40	.53	.47	.33	.40	.38	.37
Won't do something unless I absolutely have to	.45	.56	.64	.52	.38	.46	.51
Fear/anxiety won't stop me from doing important things	-.33	-.40	-.36	-.41	-.38	-.24	-.44
Would give up a lot not to feel bad	.43	.61	.67	.52	.51	.60	.67
Rarely do things that might upset me	.46	.51	.57	.68	.45	.67	.63
Hard for me to know what I am feeling	.38	.55	.48	.27	.36	.51	.42
Try to put off unpleasant tasks for as long as possible	.50	.49	.58	.46	.32	.56	.49
Go out of my way to avoid uncomfortable situations	.63	.67	.76	.63	.52	.68	.63
A big goal is to be free from painful emotions	.51	.54	.65	.49	.63	.62	.67
Work hard to keep out upsetting feelings	.48	.57	.65	.39	.52	.67	.60
Won't do something if I have doubts	.54	.50	.65	.57	.46	.55	.57
Pain always leads to suffering	.52	.56	.64	.60	.50	.50	.67

Note. Phase I = scale development samples; Phase II = scale evaluation samples; Phase III = BEAQ cross-validation samples; P = patient; S = student; C = community. In Phase I, patient  $n = 265$ , student  $n = 363$ , community  $n = 215$ ; in Phase II, patient  $n = 201$ , student  $n = 314$ ; in Phase III, student  $n = 283$ , community  $n = 295$ .

### Phase 2 Method

The full MEAQ was administered to two samples of undergraduates and psychiatric outpatients. Responses to the 15 BEAQ items were extracted from the MEAQ to evaluate their psychometric properties. Additional measures were given to assess discriminant, convergent, and concurrent associations. Specifically, it was anticipated that the BEAQ would demonstrate patterns of associations similar to those of the MEAQ—namely, that it would be strongly related to avoidance-based measures (particularly the AAQ and AAQ-II), moderately associated with measures of negative emotionality, weakly associated with other basic personality traits, and moderately related to measures of psychopathology and quality of life (see Gámez et al., 2011). The Phase 2 student and patient participants were recruited from sources independent of the sources for the Phase 1 samples (e.g., different institutions and geographic locations).

### Participants

The student sample ( $n = 314$ ) was recruited from an elementary psychology course at a large public Midwestern university using a

voluntary Internet-based sign-up system. Students were recruited from an introductory psychology course and completed questionnaires in the laboratory. Students received research credit for their participation; this counted toward the fulfillment of their course research exposure requirement. All students were given the option of writing an essay in lieu of participating in the study. The student sample was 76% female, 90% Caucasian, 3% Asian American, 3% African American, and 2% mixed or other race. Two percent identified as Hispanic or Latino. Ages ranged from 18 to 29 years ( $M = 19.16$  years,  $SD = 1.54$ ).

The patient sample ( $n = 201$ ) was recruited from various outpatient mental health clinics in the Midwest (including an adult psychiatry outpatient clinic, a community mental health clinic, and a psychology department clinic). Interested participants were given packets that could be completed at home and mailed in. Instructions at the beginning of the take-home packet requested that patients (a) respond to all questions themselves (without input from others) and (b) complete the questionnaires in a timely manner (within 2 weeks) and in a location with minimal distractions. Patients who mailed back their questionnaire were provided monetary compensation. Patients were asked to report any mental

Table 3

Correlations of the Brief Experiential Avoidance Questionnaire (BEAQ) With the Multidimensional Experiential Avoidance Questionnaire (MEAQ) Subscales

MEAQ subscales	BEAQ				
	Phase I			Phase II	
	Patient	Student	Community	Patient	Student
Behavioral Avoidance	.83	.81	.85	.77	.72
Distress Aversion	.76	.78	.78	.77	.76
Procrastination	.55	.64	.69	.59	.45
Distraction/Suppression	.50	.49	.60	.49	.60
Repression/Denial	.54	.70	.66	.48	.57
Distress Endurance	-.33	-.39	-.45	-.58	-.40

Note. Phase I = scale development samples; Phase II = scale evaluation samples. For Phase I, patient  $n = 265$ , student  $n = 363$ , community  $n = 215$ ; for Phase II, patient  $n = 201$ , student  $n = 314$ .

health diagnoses they had received; the most commonly reported diagnoses were depression (60%), or an anxiety disorder (33%). The patient sample was 73% female, 89% Caucasian, 4% African American, 3% mixed or other race, 2% Asian American, and 2% Native American. One percent identified as Hispanic or Latino. Patient ages ranged from 18 to 71 years ( $M = 41.63$  years,  $SD = 12.83$ ).

The two samples used for the Phase 2 analyses were reported previously in the original MEAQ scale development article (see Gámez et al., 2011).

## Measures

For additional detail regarding the psychometric properties of the following measures, please refer to Gámez et al. (2011).

**Convergent and discriminant measures.** Measures were included to assess basic personality traits and avoidance-related constructs (e.g., psychological inflexibility, avoidant coping, thought suppression, alexithymia).

**Big Five Inventory (BFI; John & Srivastava, 1999).** The BFI is a 44-item self-report measure that assesses the Big Five personality traits: Neuroticism, Extraversion, Openness, Agreeableness, and Conscientiousness. Items are rated on a 5-point scale ranging from *disagree strongly* to *agree strongly*. Alpha reliabilities typically range from .75 to .90 (John, Donahue, & Kentle, 1998). Scale alphas for the Phase 2 samples ranged from .79 to .83 (Neuroticism), .83 to .85 (Extraversion), .75 to .87 (Openness), .75 to .80 (Agreeableness), and .75 to .80 (Conscientiousness).

**Positive Affect and Negative Affect Schedule (PANAS; Watson, Clark, & Tellegen, 1988); Negative Affect scale.** The PANAS Negative Affect scale is a 10-item self-report measure of mood. We used the trait version of the instrument, which instructs participants to report the extent to which they generally experience various negative moods (e.g., distressed, nervous, irritable). Items are rated on a 5-point scale ranging from 1 (*very slightly or not at all*) to 5 (*extremely*). The 10-item Negative Affect scale demonstrates good internal consistency ( $\alpha = .87$ ; Watson et al., 1988). Alphas for the Phase 2 samples ranged from .83 to .89.

**AAQ (Bond & Bunce, 2003; Hayes et al., 2004).** The AAQ is a 16-item self-report measure that assesses psychological inflexibility (Hayes, 2009; a broader construct that includes EA; Bond et al., 2011). Items are rated on a 7-point scale ranging from 1 (*never true*) to 7 (*always true*). Alphas for this measure typically approach .70 (Bond & Bunce, 2003; Hayes et al., 2004). Alphas for the Phase 2 samples ranged from .70 to .74.

**AAQ-II (Bond et al., 2011).** The AAQ-II uses the same frequency response scale as the AAQ and is made up of seven items that assess psychological inflexibility (which includes EA; Bond et al., 2011). The AAQ-II demonstrates good internal consistency (alphas range from .81 to .87; Bond et al., 2011). Alphas for the Phase 2 samples ranged from .86 to .89.

**Cognitive-Behavioral Avoidance Scale (Ottenbreit & Dobson, 2004).** The Cognitive-Behavioral Avoidance Scale is a 31-item self-report measure that assesses an individual's tendency to avoid social interactions, relationship conflict, achievement, and challenges. Items are rated on a 5-point scale ranging from 1 = *not at all true for me* to 5 = *extremely true for me*. Alphas for the four scales range from .75 to .86 (Ottenbreit & Dobson, 2004). Scale alphas for the Phase 2 samples ranged from .88 to .90 (Social

Avoidance), .80 to .82 (Relationship Avoidance), .87 to .89 (Achievement Avoidance), and .76 to .81 (Challenge Avoidance).

**COPE (Carver et al., 1989); Denial scale.** The COPE is a self-report measure of coping strategies that an individual typically uses when faced with stressful situations. Items are rated on a 4-point scale ranging from 1 = *usually don't do this at all* to 4 = *usually do this a lot*. The four-item Denial scale was included here ( $\alpha = .71$ ; Carver et al., 1989). Alphas for the Phase 2 samples ranged from .80 to .82.

**Impact of Event Scale (Horowitz, Wilner, & Alvarez, 1979); Avoidance subscale.** The Impact of Event Scale is a 15-item self-report measure that assesses how frequently individuals display certain reactions to stressful events. Participants were given the following instructions: "When responding to each question, please think of a past event that has been affecting you the most during the past week." Items are rated on a 4-point scale ranging from 1 = *not at all* to 4 = *often*. Factor analyses reveal a two-factor structure that corresponds to intrusions and avoidance (Horowitz et al., 1979). The Avoidance subscale demonstrates evidence of good internal consistency, with an average coefficient alpha of .82 across 23 studies (Sundin & Horowitz, 2002). Alphas for the Phase 2 samples ranged from .82 to .83.

**White Bear Suppression Inventory (WBSI; Wegner & Zanakos, 1994).** The WBSI is a 15-item self-report measure that assesses an individual's tendency to suppress or ignore unwanted thoughts. Items are rated on a 5-point scale ranging from *strongly disagree* to *strongly agree*. The WBSI demonstrates evidence of good internal consistency, with alphas typically ranging from .87 to .89 (Muris, Merckelbach, & Horseleberg, 1996; Wegner & Zanakos, 1994). Alphas for the Phase 2 samples ranged from .91 to .92.

**Toronto Alexithymia Scale (TAS-20; Bagby et al., 1994).** The TAS-20 is a 20-item self-report measure of alexithymia, which is defined as an inability to recognize and express emotions (Sifneos, 1972) and has been conceptualized by some as a form of emotional avoidance (Stewart, Zvolensky, & Eifert, 2002). Items are rated on a 5-point scale ranging from 1 = *strongly disagree* to 5 = *strongly agree*. Alphas for the TAS-20 have regularly exceeded .80 in a variety of samples (Bagby et al., 1994; Parker, Taylor, & Bagby, 2003). Alphas for the Phase 2 samples were .85 (the same for students and patients).

**Psychopathology measures.** Structural analyses have suggested that common mental disorders can be organized into two broad classes of internalizing and externalizing disorders (Krueger, 1999; Watson, 2005). Measures were included to assess representative disorders within the two major subsets of the internalizing disorders: distress disorders (characterized by nonspecific dysphoria), and fear disorders (characterized by phobias). A final measure assessed obsessive-compulsive disorder, which is a marker of a potential additional dimension within the internalizing spectrum (see Tackett, Quilty, Sellbom, Rector, & Bagby, 2008).

**Inventory of Depression and Anxiety Symptoms—General Depression scale (IDAS-GD; Watson et al., 2007).** The IDAS-GD is a 20-item measure of depressive symptomatology. Participants are asked to rate how they have felt during the past 2 weeks on a 5-point scale ranging from 1 = *not at all* to 5 = *extremely*. The IDAS-GD scale contains at least one item relevant to all nine symptom criteria for a major depressive episode as outlined in the *DSM-5* (American Psychiatric Association, 2013). Furthermore,

this scale has demonstrated evidence of good internal consistency across student, community, patient, and adolescent populations (.89–.92; Watson et al., 2007). Alphas for the Phase 2 samples were .92 (the same for students and patients).

**Fear Questionnaire (Marks & Mathews, 1979); Social Phobia, Agoraphobia, and Blood/Injury scales.** The Fear Questionnaire includes three 5-item scales that tap avoidance of fear-provoking situations related to social phobia, agoraphobia, and blood or injury. These items are rated on a 9-point scale ranging from 0 = *would not avoid it* to 8 = *always avoid it*. We used the more reliable total phobia score (combining the three 5-item phobia scales) in our analyses. Alphas for the Phase 2 samples ranged from .84 to .86.

**Obsessive–Compulsive Inventory—Revised (Foa et al., 2002).** The Obsessive–Compulsive Inventory—Revised is an 18-item self-report measure of obsessive–compulsive symptoms. Participants are asked to rate how frequently they had experienced each symptom on a 5-point scale ranging from 1 = *never* to 5 = *almost always*. The scale demonstrates evidence of good internal consistency with alphas ranging from .81 to .90 in patient and student groups (Foa et al., 2002; Hajcak, Huppert, Simons, & Foa, 2004). Alphas for the Phase 2 samples ranged from .89 to .91.

**Quality-of-life measures.** Measures were included to assess positive mood, well-being, and life satisfaction.

**PANAS (Watson et al., 1988); Positive Affect scale.** The PANAS Positive Affect scale is a 10-item self-report measure of mood. Individuals rate the extent to which they generally experience various positive moods (e.g., active, interested, excited, inspired) on a 5-point scale ranging from 1 (*very slightly or not at all*) to 5 (*extremely*). The 10-item Positive Affect scale demonstrates evidence of good internal consistency ( $\alpha$ s = .86–.90; Watson et al., 1988). Alphas for the Phase 2 samples ranged from .88 to .90.

**Scales of Psychological Well-Being (Ryff, 1989); Purpose in Life scale.** The Scales of Psychological Well-Being were designed to measure nonhedonic aspects of well-being. The Purpose in Life scale consists of 14 items that assess the presence of goals, meaning, and directedness in a person's life. Items are rated on a 6-point scale ranging from 1 = *strongly disagree* to 6 = *strongly agree*. The Purpose in Life scale demonstrates evidence of good internal consistency, with alphas ranging from .84 to .88 (Ryff, 1989). Alphas for the Phase 2 samples ranged from .89 to .90.

**Satisfaction With Life Scale (SWLS; Diener, Emmons, Larsen, & Griffin, 1985).** The SWLS is a five-item self-report measure of general life satisfaction. Items are rated on a 7-point scale ranging from 1 = *strongly disagree* to 7 = *strongly agree*. The SWLS has demonstrated evidence of good internal consistency, with alphas ranging from .79 to .89 (Pavot & Diener, 1993). Alphas for the Phase 2 samples ranged from .86 to .90.

**Quality of Life Index (QOLI; Ferrans & Powers, 1985), modified.** The QOLI is a 33-item measure of an individual's self-rated satisfaction in several life domains. Items are rated on a 6-point scale ranging from 1 = *very dissatisfied* to 6 = *very satisfied*. The QOLI also asks participants to rate the importance of each life domain, but these ratings were not collected in the current study. Alphas for this measure are typically .90 or greater (Ferrans & Powers, 1985; Scott, 2000). An abbreviated version of the QOLI was created for use in this study; this includes single satisfaction items for each of the major domains covered in the overall instru-

ment: health, friends, family, romantic relationships, neighborhood, living situation, employment, finances, education, recreation, community involvement, spirituality, personal goals, overall happiness, and life in general. Alpha for the Phase 2 samples was .87 (the same for students and patients).

## Phase 2 Results

### Descriptive Statistics

Table 1 displays the scale means and standard deviations across the two Phase 2 samples. The mean effect size comparison (Cohen's  $d$ ) is large (patient vs. student  $d = 0.77$ ), indicating again that the BEAQ is sensitive to expected population differences in EA.

### Internal Consistency

The means, standard deviations, and internal consistency statistics for the Phase 2 samples can be found in Table 1. Although, as expected, the alphas are somewhat lower than those found in the development samples, they suggest the BEAQ retains adequate internal consistency in the validation samples ( $\alpha$ s = .80–.83; AICs = .21–.24; Clark & Watson, 1995; Nunnally, 1978). Examination of the unrotated eigenvalues via scree plot suggested that a single general factor best described the data: The first five eigenvalues for each sample were 4.03, 1.65, 1.33, 1.25, and 1.09 for students and 4.55, 1.57, 1.27, 1.16, and 0.94 for patients. EFAs extracting one factor were conducted on the validation samples to examine scale homogeneity (see Table 2). As with the alphas, factor loadings were generally consistent but somewhat lower overall compared with the Phase 1 samples (mean student loading = .141, mean patient loading = .144).

### Association With the MEAQ

Table 3 displays the correlations between the BEAQ and the MEAQ subscales across the two Phase 2 samples. Results were very similar to those found in Phase 1, with the BEAQ exhibiting moderate to high correlations with each of the six individual MEAQ subscales. The Behavioral Avoidance and Distress Aversion scales again are the MEAQ scales most strongly related to the BEAQ (mean  $r = .75$ ), whereas the Distress Endurance scale is the most weakly related in the student sample ( $r = -.40$ ), although not in the patient sample ( $r = -.58$ ). This is consistent with the pattern and performance of this scale in the Phase 2 MEAQ development study (see Gámez et al., 2011).

### Association With Related Measures

Table 4 displays the association of the BEAQ with measures of negative emotionality, basic personality, avoidance-related constructs, psychopathology, and quality of life. The BEAQ shows moderate correlations with indicators of negative emotionality (mean  $r = .47$ ), particularly in the patient sample, but generally shows stronger relations with measures of avoidance (mean  $r = .52$ )—in particular, the AAQ and AAQ-II (mean  $r = .66$ ). For example, the BEAQ is more highly correlated with measures of avoidance than with indicators of neuroticism in 14 of 20 informal comparisons. To examine this issue

Table 4

*Associations Between the Brief Experiential Avoidance Questionnaire (BEAQ), Multidimensional Experiential Avoidance Questionnaire (MEAQ), and Other Measures*

Measure	Phase II				Phase III	
	MEAQ		BEAQ		BEAQ	
	S	P	S	P	S	C
Negative emotionality						
PANAS—Negative Affect	.44	<b>.54</b>	.43	<b>.52</b>	.36	.47
BFI—Neuroticism	.44	<b>.54</b>	.41	<b>.51</b>	.41	.47
Other personality						
BFI—Extraversion	-.28	-.27	-.26	-.30	-.29	-.27
BFI—Openness	-.22	-.38	-.20	-.39	-.18	-.19
BFI—Agreeableness	-.08	-.18	-.09	-.16	-.27	-.26
BFI—Conscientiousness	-.34	-.46	-.29 <sup>b</sup>	-.41 <sup>a</sup>	-.28	-.42
Avoidance related						
AAQ—Inflexibility/Avoidance	<b>.66</b>	<b>.74</b>	<b>.64</b>	<b>.73</b>		
AAQ—II—Inflexibility/Avoidance	<b>.65</b>	<b>.62</b>	<b>.61<sup>b</sup></b>	<b>.63</b>	<b>.57</b>	<b>.65</b>
WBSI—Thought Avoidance	<b>.54</b>	<b>.56</b>	<b>.51</b>	<b>.56</b>		
IES—Stress Avoidance	<b>.53</b>	.41	<b>.51</b>	.34 <sup>b</sup>		
TAS—Emotional Avoidance	<b>.54</b>	<b>.53</b>	<b>.54</b>	.48 <sup>b</sup>		
CBAS—Social Avoidance	.37	<b>.54</b>	.37	<b>.57</b>		
CBAS—Relationship Avoidance	<b>.55</b>	<b>.60</b>	<b>.52</b>	<b>.58</b>		
CBAS—Achievement Avoidance	.44	<b>.60</b>	.40 <sup>a</sup>	<b>.59</b>		
CBAS—Challenge Avoidance	<b>.55</b>	<b>.58</b>	<b>.53</b>	<b>.59</b>		
COPE—Denial	.40	.38	.37	.33 <sup>a</sup>		
Psychopathology						
IDAS—Depression	<b>.52</b>	<b>.53</b>	.48 <sup>a</sup>	<b>.51</b>	.40	<b>.50</b>
FQ—Situational Phobias	.41	<b>.53</b>	.41	<b>.53</b>		
OCI-R—OCD Symptoms	.38	.38	.40	.40		
Quality of life						
PANAS—Positive Affect	-.38	<b>-.54</b>	-.35	<b>-.52</b>	-.38	-.34
SPWB—Purpose in Life	-.46	<b>-.61</b>	-.41 <sup>b</sup>	<b>-.61</b>		
SWLS—Life Satisfaction	-.34	-.37	-.32	-.37	-.32	-.38
QOLI—Quality of Life	-.34	-.49	-.34	-.48		

*Note.* Phase II = scale evaluation samples; Phase III = BEAQ cross-validation samples; P = patient; S = student; C = community; PANAS = Positive and Negative Affect Schedule; BFI = Big Five Inventory; AAQ = Acceptance and Action Questionnaire; AAQ-II = Acceptance and Action Questionnaire, second version; WBSI = White Bear Suppression Inventory; IES = Impact of Event Scale; TAS = Toronto Alexithymia Scale; CBAS = Cognitive-Behavioral Avoidance Scale; IDAS = Inventory of Depression and Anxiety Symptoms; FQ = Fear Questionnaire; OCI-R = Obsessive-Compulsive Inventory-Revised; SPWB = Scales of Psychological Well Being; SWLS = Satisfaction With Life Scale; QOLI = Quality of Life Index. In Phase II, patient  $n = 201$ , student  $n = 314$ ; in Phase III, student  $n = 283$ , community  $n = 295$ . All correlations of .50 or greater are in bold.

<sup>a</sup> The measure's association with BEAQ and MEAQ (Phase II) is significantly different at  $p < .05$ . <sup>b</sup> The measure's association with BEAQ and MEAQ (Phase II) is significantly different at  $p < .01$ .

further, we ran follow-up significance analyses using the Williams modification of the Hotelling test for two correlations with one common variable (Kenny, 1987). They revealed that the BEAQ is significantly more associated with the avoidance-related measures relative to neuroticism in eight of 20 comparisons ( $Z$  scores for each comparison were  $> 1.96$ ,  $p < .05$ , two-tailed).

As expected, associations with scales measuring other basic personality traits (extraversion, openness, agreeableness, conscientiousness) are smaller (mean  $r = .26$ ). As with the MEAQ, we find stronger (negative) associations between the BEAQ and openness and conscientiousness in patients. Finally, the BEAQ demonstrates robust relations with measures of psychopathology (mean  $r = .46$ ) and quality of life (mean  $r = -.43$ ), particularly with scales assessing depression, situational phobias, and purpose in life (mean  $r = .149$ ). These correlations remain statistically significant ( $p < .01$ ) even after controlling for the effects of neuroticism, although their overall mag-

nitude is attenuated by a mean correlation of .12 (psychopathology measures) and .14 (quality of life measures) across samples.

For comparison, Table 4 also includes parallel correlations with the MEAQ total score. There is a tendency for the BEAQ correlations to be attenuated slightly relative to the MEAQ (difference of  $r = -.02$ , on average), but the reduced instrument otherwise performs remarkably similarly despite 47 fewer items. Follow-up two-tailed significance tests using the Williams modification of the Hotelling test for two correlations with one common variable (Kenny, 1987) revealed that only nine (out of a total of 46) BEAQ correlations differed significantly from their MEAQ counterparts.

### Phase 3 Method

Both the Phase 1 and Phase 2 results were based on a methodology in which the BEAQ items were administered as part of the full

62-item MEAQ (i.e., incorporated among 47 other items and in a different order of presentation). To examine whether the resulting stand-alone measure would generate similar results, we administered the reduced 15-item BEAQ to two new samples of undergraduates and community adults. Measures were also given to assess discriminant, convergent, and concurrent associations. It was anticipated that the stand-alone BEAQ would demonstrate similar psychometric properties and yield results comparable to those found in the Phase 1 and Phase 2 analyses. The Phase 3 student and patient participants were recruited from sources independent of the sources for both the Phase 1 and the Phase 2 samples.

## Participants

The student sample ( $n = 283$ ) was recruited from a large public Southern university using a voluntary Internet-based sign-up system. Students were recruited from introductory psychology courses and completed questionnaires online using SurveyMonkey. Students received research credit for their participation; this counted toward the fulfillment of their course research exposure requirement. All students were given the option of writing an essay in lieu of participating in the study. The sample was 76% female, 74% Caucasian, 12% African American, and 9% Asian American, with 23% self-reporting as Hispanic or Latino. Ages ranged from 18 to 53 years ( $M = 20.80$  years,  $SD = 4.19$ ).

The community sample ( $n = 295$ ) was recruited online from the Mechanical Turk (MTurk) system hosted by Amazon Web Services (<https://www.mturk.com>). Anyone with Internet access and a working e-mail address can create an account to access the system. Workers in the MTurk system viewed the study's description on the list of human intelligence tasks (HITs) requesters posted on the site. Participants made their decisions to accept the HIT on the basis of the information provided in the description, such as the length of time needed to complete the task or study (less than 20 min), the amount of monetary compensation offered (\$3), and whether they met the qualification criteria (18 years of age or older, 95% approval rating, and more than 500 HITs completed). On agreeing to participate, respondents viewed an informed consent document and were given 1 day to complete and submit the survey. All respondents were restricted from participating more than once.

Research has demonstrated that responses collected via MTurk are comparable to data collected via more traditional methods (see Buhrmester, Kwang, & Gosling, 2011). The community sample was 50% female, 82% Caucasian, 9% Asian American, and 6% African American, with 8% self-reporting as Hispanic or Latino. Fifty percent described themselves as single, whereas 41% were married or cohabitating (the remainder were widowed or divorced). Ages ranged from 18 to 66 years ( $M = 34.00$  years,  $SD = 11.26$ ). Respondents were restricted to those residing in the United States.

## Measures

The following measures (previously described in the Phase 2 Method section) were administered.

**BFI (John & Srivastava, 1999).** Scale alphas for the Phase 3 samples ranged from .82 to .89 (Neuroticism), .84 to .90 (Extraversion), .77 to .83 (Openness), .75 to .84 (Agreeableness), and .77 to .87 (Conscientiousness).

**PANAS (Watson et al., 1988); Negative Affect Scale.** Alphas for the Phase 3 samples ranged from .87 to .92.

**AAQ-II (Bond et al., 2011).** Alphas for the Phase 3 samples ranged from .89 to .91.

**IDAS-GD (Watson et al., 2007).** Alphas for the Phase 3 samples ranged from .89 to .93.

**PANAS (Watson et al., 1988); Positive Affect scale.** Alphas for the Phase 3 samples ranged from .87 to .91.

**SWLS (Diener et al., 1985).** Alphas for the Phase 3 samples ranged from .87 to .94.

## Phase 3 Results

### Descriptive Statistics

Table 1 displays the descriptive statistics for the two new samples. The Phase 3 student mean is nearly identical to the Phase 1 student mean ( $d = -0.04$ ), although somewhat greater than the Phase 2 student mean ( $d = 0.38$ ). The Phase 3 community mean is higher than the Phase 1 community mean ( $d = 0.52$ ), exhibiting the most similarity to the Phase 1 student mean ( $d = 0.10$ ). Overall, the two new sample means (average  $M = 48.55$ , mean  $SD = 11.24$ ) fit well within the range of those found in the five Phase 1 and 2 samples (range of  $M$ s = 43.33–56.41).

### Internal Consistency

Internal consistency statistics in the Phase 3 samples are very similar to prior results (mean  $\alpha = .84$ , mean AIC = .27 across five Phase 1 and 2 samples; see Table 1). Extracting a single factor to examine scale homogeneity in the Phase 3 samples resulted in a similar degree of factor loading (mean factor loading = 1.531; see Table 2) compared with the Phase 1 and 2 samples (mean factor loading = 1.511). One item has a loading less than 1.301 in the Phase 3 student sample (–.24) yet exhibits a moderate loading in the community sample (–.44). All other factor loadings range from 1.311 to 1.681.

### Association With Related Measures

Table 4 displays associations between the BEAQ and other measures in the Phase 3 samples. In general, associations are very similar to those found in the Phase 2 samples. The mean of absolute differences in correlations between the Phase 2 and 3 student samples is only .05, with no consistent pattern toward stronger or weaker associations. The same results hold true for the Phase 3 community sample when compared with the mean Phase 2 student and patient correlations.

### Summary

Taken together, these results indicate that isolating and reordering the BEAQ items into a reduced 15-item scale does not significantly alter the conclusions drawn from the original scale development and evaluation samples. More generally, the basic psychometric properties of the BEAQ replicate quite well across student, community, and patient samples.

## Discussion

Experiential avoidance has received a great deal of recent attention in the clinical and research literatures because of its im-

portance in understanding and explaining psychopathology and maladaptive behavior patterns. However, improved measurement of this important construct has been needed.

### Advantages of the BEAQ

Initial attempts at measuring EA (i.e., the AAQ; Hayes et al., 2004) demonstrated unsatisfactory internal consistency (Bond et al., 2011). Results from the current studies indicate that the BEAQ is an improvement in this area, with alphas ranging from .80 to .89 (see Table 1) across seven samples. Furthermore, the initial focus on a brief measure may have caused researchers to overlook important content coverage of such a large, diverse construct (Gámez et al., 2011). The MEAQ was designed to measure EA more comprehensively. The BEAQ, although brief, includes content from each of the MEAQ's six subscales, which is reflected in its association with each of the MEAQ domains (mean  $r = .62$ ; see Table 3).

Although designed to assess a broader yet related construct (viz. psychological flexibility), the authors of the AAQ-II indicated that it can still be used as a measure of EA (see Bond et al., 2011). However, AAQ-II item content strongly emphasizes dysfunctional distress; it is not surprising, therefore, that the AAQ-II exhibits stronger associations with indicators of negative emotionality and poor quality of life than it does with measures of avoidance (see Gámez et al., 2011). The BEAQ, although related to measures of negative emotionality and poor quality of life (see Table 4) tends to be more strongly associated with measures of avoidance across populations.

Finally, although the MEAQ was designed to address many of the issues outlined above, its length (62 items) may be impractical for certain uses. The BEAQ is more than 75% shorter (reducing administration time from approximately 12 min to 3 min), taps much of the same content, and exhibits nearly identical convergent and discriminant associations as the full instrument (see Table 4). The major limitation associated with this reduction in items is that the BEAQ is not suitable for measuring subdimensions of EA. For example, researchers may want to assess specific components of EA to examine differential relations among psychiatric diagnoses or other markers of psychopathology, whereas clinicians may want to use this additional specificity to tailor the emphasis of a particular intervention (e.g., whether avoidance is primarily covert, as indicated by the Repression/Denial subscale, or whether negative judgments of distress are particularly salient, as indicated by the Distress Evaluation subscale).

### Strengths and Limitations

BEAQ item selection was informed by factor analytic methods (see Clark & Watson, 1995). Multiple populations (college students, psychiatric outpatients, community adults) were used to promote generalizability and external validity (see Cook & Campbell, 1979), and two additional phases of data collection (comprising four separate samples) were conducted to ensure that the initial results were replicable and not an artifact of capitalizing on chance (Lindsay & Ehrenberg, 1993; N. C. Smith, 1970). We examined a wide range of avoidance-related measures, as well as associations with basic personality traits, psychopathology, and quality of life. The resulting brief measure of EA was internally consistent, assessed multiple facets of the underlying construct, and was clearly distinguishable from negative emotionality.

At the same time, the current studies have several limitations that should be addressed in future research. First, the relative lack of diversity in some samples may limit the generalizability of some of the conclusions. Second, we did not obtain evidence related to test-retest reliability (although this is often assessed after initial scale development; see Watson, 2004). Finally, all data were limited to self-report methodology and, therefore, vulnerable to the limitations associated with using a single method (e.g., inflated estimates of associations between constructs; Campbell & Fiske, 1959; Podsakoff, MacKenzie, Lee, & Podsakoff, 2003). It will be important for future research to validate the BEAQ against data collected using other methods (e.g., informant and clinician ratings).

### Implications

Researchers and clinicians both must be confident that the measures they use reliably assess what they are supposed to be assessing (as opposed to assessing measurement error, neuroticism, or some other construct). The concept of EA is extremely broad and cuts across multiple theories, which can make it particularly difficult to measure. However, as with the development of the MEAQ, the creation of the BEAQ should provide a reliable assessment tool for those who are interested in continuing to study and measure EA.

This briefer assessment of EA now will make it easier for clinicians to use it in helping to monitor and evaluate treatment progress (where repeated, multiple assessments with a longer measure may have been unwieldy). It is hoped that this will also spur additional consideration of EA as a possible mediating variable in treatment outcome studies. Finally, the abbreviated length should make it easier to include EA as a variable in any research study that may not have sufficient space for the MEAQ.

Finally, the results from these studies add to the growing body of support for EA as an important concept for helping to explain dysfunction and provide evidence for the distinction of internal experiences (negative emotionality) and associated behavioral responses (EA). Ongoing research will continue to elucidate the importance and impact that can be ascribed to distress relative to the avoidance of distress.

### References

- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: Author.
- Bagby, R. M., Parker, J. D. A., & Taylor, G. J. (1994). The Twenty-Item Toronto Alexithymia Scale: I. Item selection and cross-validation of the factor structure. *Journal of Psychosomatic Research*, 38, 23–32. doi: 10.1016/0022-3999(94)90005-1
- Bond, F. W., & Bunce, D. (2003). The role of acceptance and job control in mental health, job satisfaction, and work performance. *Journal of Applied Psychology*, 88, 1057–1067. doi:10.1037/0021-9010.88.6.1057
- Bond, F. W., Hayes, S. C., Baer, R. A., Carpenter, K. M., Guenole, N., Orcutt, H. K., . . . Zettle, R. D. (2011). Preliminary psychometric properties of the Acceptance and Action Questionnaire—II: A revised measure of psychological inflexibility and experiential avoidance. *Behavior Therapy*, 42, 676–688. doi:10.1016/j.beth.2011.03.007
- Buhrmester, M., Kwang, T., & Gosling, S. D. (2011). Amazon's Mechanical Turk: A new source of inexpensive, yet high-quality, data? *Perspectives on Psychological Science*, 6, 3–5. doi:10.1177/1745691610393980
- Campbell, D. T., & Fiske, D. W. (1959). Convergent and discriminant validation by the multitrait-multimethod matrix. *Psychological Bulletin*, 56, 81–105. doi:10.1037/h0046016

- Carver, C. S., Scheier, M. F., & Weintraub, J. K. (1989). Assessing coping strategies: A theoretically based approach. *Journal of Personality and Social Psychology*, 56, 267–283. doi:10.1037/0022-3514.56.2.267
- Chawla, N., & Ostafin, B. (2007). Experiential avoidance as a functional dimensional approach to psychopathology: An empirical review. *Journal of Clinical Psychology*, 63, 871–890. doi:10.1002/jclp.20400
- Clark, L. A., & Watson, D. (1995). Constructing validity: Basic issues in objective scale development. *Psychological Assessment*, 7, 309–319. doi:10.1037/1040-3590.7.3.309
- Cook, T. D., & Campbell, D. T. (1979). *Quasi-experimentation: Design & analysis issues for field settings*. Boston, MA: Houghton Mifflin.
- Costa, P. T., & McCrae, R. R. (1992). *Revised NEO Personality Inventory (NEO-PI-R) and NEO Five-Factor Inventory (NEO-FFI) professional manual*. Odessa, FL: Psychological Assessment Resources.
- Diener, E., Emmons, R. A., Larsen, R. J., & Griffin, S. (1985). The Satisfaction With Life Scale. *Journal of Personality Assessment*, 49, 71–75. doi:10.1207/s15327752jpa4901\_13
- Ferrans, C. E., & Powers, M. J. (1985). Quality of Life Index: Development and psychometric properties. *Advances in Nursing Science*, 8, 15–24.
- First, M. B., Spitzer, R. L., Gibbon, M., & Williams, J. B. W. (2002). *Structured Clinical Interview for DSM-IV-TR Axis I Disorders, Research Version, Patient Edition*. (SCID-I/P). New York, NY: New York State Psychiatric Institute, Biometrics Research.
- Foa, E. B., Huppert, J. D., Leiberg, S., Langner, R., Kichic, R., Hajcak, G., & Salkovskis, P. (2002). The Obsessive–Compulsive Inventory: Development and validation of a short version. *Psychological Assessment*, 14, 485–496. doi:10.1037/1040-3590.14.4.485
- Gámez, W., Chmielewski, M., Kotov, R., Ruggero, C., & Watson, D. (2011). Development of a measure of experiential avoidance: The Multidimensional Experiential Avoidance Questionnaire. *Psychological Assessment*, 23, 692–713. doi:10.1037/a0023242
- Hajcak, G., Huppert, J. D., Simons, R. F., & Foa, E. B. (2004). Psychometric properties of the OCI-R in a college sample. *Behaviour Research and Therapy*, 42, 115–123. doi:10.1016/j.brat.2003.08.002
- Hayes, S. C. (2009, December 27). *Acceptance and Action Questionnaire (AAQ) and variations*. Retrieved from [http://contextualpsychology.org/acceptance\\_action\\_questionnaire\\_aaq\\_and\\_variations](http://contextualpsychology.org/acceptance_action_questionnaire_aaq_and_variations)
- Hayes, S. C., Strosahl, K. D., & Wilson, K. G. (2012). *Acceptance and commitment therapy: The process and practice of mindful change* (2nd ed.). New York, NY: Guilford Press.
- Hayes, S. C., Strosahl, K. D., Wilson, K. G., Bissett, R. T., Pistorello, J., Toarmino, D., . . . McCurry, S. M. (2004). Measuring experiential avoidance: A preliminary test of a working model. *The Psychological Record*, 54, 553–578.
- Hayes, S. C., Wilson, K. G., Gifford, E. V., Follette, V. M., & Strosahl, K. (1996). Experiential avoidance and behavioral disorders: A functional dimensional approach to diagnosis and treatment. *Journal of Consulting and Clinical Psychology*, 64, 1152–1168. doi:10.1037/0022-006X.64.6.1152
- Horowitz, M., Wilner, N., & Alvarez, W. (1979). Impact of Event Scale: A measure of subjective stress. *Psychosomatic Medicine*, 41, 209–218.
- John, O. P., Donahue, E. M., & Kentle, R. L. (1991). *The Big Five Inventory: Versions 4a and 54*. Berkeley: University of California, Berkeley, Institute of Personality and Social Research.
- John, O. P., & Srivastava, S. (1999). The Big Five trait taxonomy: History, measurement, and theoretical perspectives. In L. A. Pervin & O. P. John (Eds.), *Handbook of personality: Theory and research* (2nd ed., pp. 102–138). New York, NY: Guilford Press.
- Kenny, D. A. (1987). *Statistics for the social and behavioral sciences*. Boston, MA: Little, Brown.
- Kohlenberg, R. J., & Tsai, M. (2007). *Functional analytic psychotherapy: Creating intense and curative therapeutic relationships*. New York, NY: Springer.
- Krueger, R. F. (1999). The structure of common mental disorders. *Archives of General Psychiatry*, 56, 921–926. doi:10.1001/archpsyc.56.10.921
- Lindsay, R. M., & Ehrenberg, A. S. C. (1993). The design of replicated studies. *The American Statistician*, 47, 217–228.
- Linehan, M. M. (1993). *Cognitive-behavioral treatment of borderline personality disorder*. New York, NY: Guilford Press.
- Marks, I. M., & Mathews, A. M. (1979). Brief standard self-rating for phobic patients. *Behaviour Research and Therapy*, 17, 263–267. doi:10.1016/0005-7967(79)90041-X
- Martell, C. R., Addis, M. E., & Jacobson, N. S. (2001). *Depression in context: Strategies for guided action*. New York, NY: Norton.
- Muris, P., Merckelbach, H., & Horselenberg, R. (1996). Individual differences in thought suppression: The White Bear Suppression Inventory: Factor structure, reliability, validity, and correlates. *Behaviour Research and Therapy*, 34, 501–513. doi:10.1016/0005-7967(96)00005-8
- Nunnally, J. C. (1978). *Psychometric theory* (2nd ed.). New York, NY: McGraw-Hill.
- Ottenbreit, N. D., & Dobson, K. S. (2004). Avoidance and depression: The construction of the Cognitive–Behavioral Avoidance Scale. *Behaviour Research and Therapy*, 42, 293–313. doi:10.1016/S0005-7967(03)00140-2
- Parker, J. D. A., Taylor, G. J., & Bagby, R. M. (2003). The twenty-item Toronto Alexithymia Scale—III: Reliability and factorial validity in a community population. *Journal of Psychosomatic Research*, 55, 269–275. doi:10.1016/S0022-3999(02)00578-0
- Pavot, W., & Diener, E. (1993). Review of the Satisfaction With Life Scale. *Psychological Assessment*, 5, 164–172. doi:10.1037/1040-3590.5.2.164
- Podsakoff, P. M., MacKenzie, S. B., Lee, J., & Podsakoff, N. P. (2003). Common method biases in behavioral research: A critical review of the literature and recommended remedies. *Journal of Applied Psychology*, 88, 879–903. doi:10.1037/0021-9010.88.5.879
- Ryff, C. D. (1989). Happiness is everything, or is it? Explorations on the meaning of psychological well-being. *Journal of Personality and Social Psychology*, 57, 1069–1081. doi:10.1037/0022-3514.57.6.1069
- Scott, L. D. (2000). Caregiving and care receiving among a technologically dependent heart failure population. *Advances in Nursing Science*, 23, 82–97.
- Sifneos, P. E. (1972). *Short-term psychotherapy and emotional crisis*. Cambridge, MA: Harvard University Press.
- Simons, J. S., & Gaher, R. M. (2005). The Distress Tolerance Scale: Development and validation of a self-report measure. *Motivation and Emotion*, 29, 83–102. doi:10.1007/s11031-005-7955-3
- Smith, G. T., McCarthy, D. M., & Anderson, K. G. (2000). On the sins of short-form development. *Psychological Assessment*, 12, 102–111. doi:10.1037/1040-3590.12.1.102
- Smith, N. C. (1970). Replication studies: A neglected aspect of psychological research. *American Psychologist*, 25, 970–975. doi:10.1037/h0029774
- Stewart, S. H., Zvolensky, M. J., & Eifert, G. H. (2002). The relations of anxiety sensitivity, experiential avoidance, and alexithymic coping to young adults' motivations for drinking. *Behavior Modification*, 26, 274–296. doi:10.1177/0145445502026002007
- Substance Abuse and Mental Health Services Administration. (2011). *Results from the 2010 National Survey on Drug Use and Health: Summary of national findings* (NSDUH Series H-41, HHS Publication No. 11-4658). Retrieved from <http://www.samhsa.gov/data/NSDUH/2k10NSDUH/2k10Results.htm>
- Sundin, E. C., & Horowitz, M. J. (2002). Impact of Event Scale: Psychometric properties. *British Journal of Psychiatry*, 180, 205–209. doi:10.1192/bjp.180.3.205
- Tackett, J. L., Quilty, L. C., Sellbom, M., Rector, N. A., & Bagby, R. M. (2008). Additional evidence for a quantitative hierarchical model of mood

- and anxiety disorders for *DSM-V*: The context of personality structure. *Journal of Abnormal Psychology*, 117, 812–825. doi:10.1037/a0013795
- Watson, D. (2004). Stability versus change, dependability versus error: Issues in the assessment of personality over time. *Journal of Research in Personality*, 38, 319–350. doi:10.1016/j.jrp.2004.03.001
- Watson, D. (2005). Rethinking the mood and anxiety disorders: A quantitative hierarchical model for *DSM-V*. *Journal of Abnormal Psychology*, 114, 522–536. doi:10.1037/0021-843X.114.4.522
- Watson, D., Clark, L. A., & Tellegen, A. (1988). Development and validation of brief measures of positive and negative affect: The PANAS scales. *Journal of Personality and Social Psychology*, 54, 1063–1070. doi:10.1037/0022-3514.54.6.1063
- Watson, D., O'Hara, M. W., Simms, L. J., Kotov, R., Chmielewski, M., McDade-Montez, E. A., . . . Stuart, S. (2007). Development and validation of the Inventory of Depression and Anxiety Symptoms (IDAS). *Psychological Assessment*, 19, 253–268. doi:10.1037/1040-3590.19.3.253
- Wegner, D. M., & Zanakos, S. (1994). Chronic thought suppression. *Journal of Personality*, 62, 615–640. doi:10.1111/j.1467-6494.1994.tb00311.x

## Appendix

### Brief Experiential Avoidance Questionnaire

Please indicate the extent to which you agree or disagree with each of the following statements

	1	2	3	4	5	6
	strongly disagree	moderately disagree	slightly disagree	slightly agree	moderately agree	strongly agree
1. The key to a good life is never feeling any pain	1	2	3	4	5	6
2. I'm quick to leave any situation that makes me feel uneasy	1	2	3	4	5	6
3. When unpleasant memories come to me, I try to put them out of my mind	1	2	3	4	5	6
4. I feel disconnected from my emotions	1	2	3	4	5	6
5. I won't do something until I absolutely have to	1	2	3	4	5	6
6. Fear or anxiety won't stop me from doing something important	1	2	3	4	5	6
7. I would give up a lot not to feel bad	1	2	3	4	5	6
8. I rarely do something if there is a chance that it will upset me	1	2	3	4	5	6
9. It's hard for me to know what I'm feeling	1	2	3	4	5	6
10. I try to put off unpleasant tasks for as long as possible	1	2	3	4	5	6
11. I go out of my way to avoid uncomfortable situations	1	2	3	4	5	6
12. One of my big goals is to be free from painful emotions	1	2	3	4	5	6
13. I work hard to keep out upsetting feelings	1	2	3	4	5	6
14. If I have any doubts about doing something, I just won't do it	1	2	3	4	5	6
15. Pain always leads to suffering	1	2	3	4	5	6

*Note.* To score, first reverse key Item 6 (i.e., subtract the value from 7), then sum all items.

Received March 12, 2012  
 Revision received July 22, 2013  
 Accepted August 6, 2013 ■

Copyright of Psychological Assessment is the property of American Psychological Association and its content may not be copied or emailed to multiple sites or posted to a listserv without the copyright holder's express written permission. However, users may print, download, or email articles for individual use.