Available online at www.sciencedirect.com
ScienceDirect
Behavior Therapy 42 (2011) 676–688
Behavior Therapy
www.elsevier.com/locate/bt

Preliminary Psychometric Properties of the Acceptance and Action Questionnaire–II: A Revised Measure of Psychological Inflexibility and Experiential Avoidance

Frank W. Bond
Goldsmiths, University of London

Steven C. Hayes
University of Nevada, Reno

Ruth A. Baer
University of Kentucky

Kenneth M. Carpenter
Columbia University, College of Physicians and Surgeons

Nigel Guenole
Goldsmiths, University of London

Holly K. Orcutt
Northern Illinois University

Tom Waltz
University of Nevada, Reno

Robert D. Zettle
Wichita State University

The present research describes the development and psychometric evaluation of a second version of the Acceptance and Action Questionnaire (AAQ-II), which assesses the construct referred to as, variously, acceptance, experiential avoidance, and psychological inflexibility. Results from 2,816 participants across six samples indicate the satisfactory structure, reliability, and validity of this measure. For example, the mean alpha coefficient is .84 (.78–.88), and the 3- and 12-month test–retest reliability is .81 and .79, respectively. Results indicate that AAQ-II scores concurrently, longitudinally, and incrementally predict a range of outcomes, from mental health to work absence rates, that are consistent with its underlying theory. The AAQ-II also demonstrates appropriate discriminant validity. The AAQ-II appears to measure the same concept as the AAQ-I (r=.97) but with better psychometric consistency.

Authorship order was alphabetically determined for Kenneth M. Carpenter, Nigel Guenole, Holly K. Orcutt, Tom Waltz, and Robert D. Zettle. We should like to thank the following people for their important contribution to this research: Laura Curtiss, Eric J. Fox, Magda Kulesza, Susan M. Orsillo, Lizabeth Roemer, and Kelly G. Wilson.

Address correspondence to Frank W. Bond, Ph.D., Department of Psychology, Goldsmiths, University of London, New Cross, London SE14 6NW, United Kingdom; e-mail: F.Bond@gold.ac.uk.

0005-7894/xx/xxx-xxx/$1.00/0

Keywords: psychological flexibility; experiential avoidance; acceptance; AAQ; psychological inflexibility

THERE IS A BROAD and growing body of evidence that mental health and behavioral effectiveness are influenced more by how people relate to their thoughts and feelings than by their form (e.g., how negative they are). This basic finding has been shown in many specific areas. For example, in chronic pain, psychosocial disability is predicted more by the experiential avoidance of pain than by the degree of pain (McCracken, 1998). A number of concepts central to modern empirical clinical methods have emerged with this same basic theme, including distress tolerance (e.g., Brown, Lejuez, Kahler, & Strong, 2002; Schmidt, Richey, Cromer, & Buckner, 2007), thought suppression (e.g., Wenzlaff & Wegner, 2000), and mindfulness (Baer, 2003). This core insight is key to a number of the newer contextual cognitive behavior therapy (CBT) approaches to treatment such as mindfulness based cognitive therapy (MBCT; Segal, Williams, & Teasdale, 2001), dialectical behavior therapy (DBT; Linehan, 1993), metacognitive therapy (Wells, 2000), and acceptance and commitment therapy (ACT; Hayes, Strosahl, & Wilson, 1999). The purpose of the present paper is to examine the measurement of a concept that developed originally within ACT, and that seems to apply to other forms of contextual CBTs (e.g., see Rüsch et al., 2008).

THE ACCEPTANCE AND ACTION QUESTIONNAIRE

The Acceptance and Action Questionnaire (AAQ; Hayes et al., 2004) is the most widely used measure of experiential avoidance and psychological inflexibility. The original item pool for this short (9 to 16 items, depending on the version) Likert-style scale was generated by ACT therapists and researchers to represent the kind of phenomena that constitutes this unidimensional construct. As such, the final scale contained items on negative evaluations of feelings (e.g., "Anxiety is bad"), avoidance of thoughts and feelings (e.g., "I try to suppress thoughts and feelings that I don't like by just not thinking about them"), distinguishing a thought from its referent (e.g., "When I evaluate something negatively, I usually recognize that this is just a reaction, not an objective fact"), and behavioral adjustment in the presence of difficult thoughts or feelings (e.g., "I am able to take action on a problem even if I am uncertain what is the right thing to do.").

The AAQ has proven to be broadly useful. A meta-analysis of 27 studies that used this measure found that it predicted a wide range of quality-of-life outcomes (e.g., depression, anxiety, general mental health, job satisfaction, future work absence, and future job performance), with an average effect size of $r = .42$ (Hayes, Luoma, Bond, Masuda, & Lillis, 2006; see also Chawla & Ostafin, 2007). The AAQ shows these effects even after controlling for one or more individual characteristics, such as emotional intelligence, negative affectivity, thought suppression, social desirability, and locus of control (see Bond, Hayes, & Barnes-Holmes, 2006, for a review). Importantly, the AAQ does not just correlate with quality-of-life indices. Studies have shown that the AAQ mediates the impact of other coping processes such as cognitive reappraisal (Kashdan, Barrios, Forsyth, & Steger, 2006), moderates the effect of treatment (Masuda et al., 2007), and in some studies mediates the impact of ACT (Bond & Bunce, 2000; Flaxman & Bond, 2010). The AAQ also predicts dropout from DBT (Rüsch et al., 2008); in addition, reductions in experiential avoidance, as measured by the AAQ, predict corresponding reductions in depression among DBT patients seeking treatment for borderline personality disorder (Berking, Neacsiu, Comtois, & Linehan, 2009). Thus, the AAQ appears more broadly applicable to modern contextual CBT methods, not just ACT.

The success of the AAQ has led to a growing number of versions that are tailored to particular applied areas or specific populations, such as pain (McCracken, Vowles, & Eccleston, 2004), smoking (Gifford et al., 2004), diabetes management (Gregg, Callaghan, Hayes, & Glenn-Lawson, 2007), tinnitus (Westin, Andersson, & Hayes, 2008), weight (Lillis & Hayes, 2008), coping with epilepsy (Lundgren, Dahl, & Hayes, 2008), and coping with psychotic symptoms (Shawyer et al., 2007), among several others. So far, all of these specific versions work well in predicting outcomes within their respective areas and have been particularly effective as mediators of ACT interventions that target these specific problems (e.g., Gifford et al., 2004; Gregg et al., 2007; Lillis & Hayes, 2008; Lundgren et al., 2008). However, a more general AAQ that can be used in a wide variety of contexts remains important for studying this theoretical model and the processes that underlie therapeutic and behavioral change.

The Achilles' Heel of the AAQ-I: Comprehension and Reliability

In many studies, the internal consistency of the AAQ (which from here forward we will term the AAQ-I) has often been a problem. In an early validation study (Hayes et al., 2004), the alpha coefficient of this unidimensional measure was a just satisfactory .70, and its test–retest reliability was .64 over 4 months. In subsequent studies, alpha levels have sometimes been