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An Examination of Experiential Avoidance as a Vulnerability Factor for Posttraumatic Stress
Symptoms and Excessive Behaviors in Parent and Young Adult Child Dyads

by

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Thesis

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Abstract

Experiential avoidance is receiving increasing conceptual and empirical review as an emotion regulation strategy and crucial factor in the development and maintenance of symptoms of Posttraumatic Stress Disorder (PTSD; Kumpula, Orcutt, Bardeen, & Varkovitzky, 2011; Thompson & Waltz, 2010). It is also implicated in a variety of topographically dissimilar problem behaviors (Kingston, Clarke, & Remington, 2010; Mansell et al., 2009) and poor mental health outcomes. The transmission of effective emotion regulatory strategies (Duncombe et al., 2012) is increasingly important to understanding the development of these problems.

Experiential avoidance may be a learned response style from one's parent. This conceptual model was used to test the predictive power of parent experiential avoidance to young adult child experiential avoidance, posttraumatic stress symptoms, and excessive behaviors. Cross-sectional survey methodology was employed in a university setting, using a sample of parent and young adult child dyads. Significant discrepancies in the measurement of experiential avoidance were observed. Overall, the Acceptance and Action Questionnaire-II was the strongest predictor of posttraumatic stress symptoms and excessive behaviors between and within dyads, above and beyond trauma itself. Parent experiential avoidance influenced young adult child experiential avoidance and parents appeared to engage in more harmful behaviors than their young adult children. Implications for understanding the influence of parent behaviors and experiential avoidance for young adults are discussed.

Keywords: experiential avoidance, trauma, families, AAQ-II, MEAQ

Table of Contents

Acknowledgments..... ii

Abstract..... iii

Problem Statement..... 1

Review of the Empirical Literature..... 5

 Emotion Regulation 5

 Experiential Avoidance 7

 Experiential Avoidance and Excessive Behaviors 10

 Parent-Child Emotion Regulation and Experiential Avoidance..... 12

 Effects of Parent Psychopathology on Child Emotion Regulation 15

 Parent Experiential Avoidance..... 16

 Parent-Child Experiential Avoidance and Excessive Behaviors..... 17

 Harmful Sequelae of Trauma Exposure..... 19

 Consequences of trauma exposure for children 20

 The Role of Experiential Avoidance in Posttraumatic Stress Disorder 21

 Experiential avoidance and peritraumatic dissociation..... 23

 Experiential avoidance, thought suppression, and alexithymia 25

 Experiential avoidance, trauma exposure, and the family context 27

 Psychological Resilience and Emotion Regulation 29

 Rationale and Hypotheses 34

Method..... 39

 Participants 39

Procedure and Recruitment.....	39
Procedure and recruitment method one	39
Procedure and recruitment method two	42
Measures	43
Multidimensional experiential avoidance questionnaire	43
Acceptance and action questionnaire-II.....	44
Composite measure of problem behaviors.....	45
Life events checklist	45
Posttraumatic stress disorder checklist-civilian version	46
Design.....	47
Results.....	48
Preliminary Data Analyses	48
Dyadic analyses and restructuring the dataset.....	48
Normality, linearity, and homoscedasticity	49
Bivariate correlations	52
Parent measure relationships	52
Young adult child measure relationships	53
Dyadic relationships	53
Trauma history and posttraumatic stress relationships.....	54
Hierarchical Multiple Linear Regression Analyses.....	54
Regression testing hypothesis (2a).....	55
Regression testing hypothesis (2b).....	55
Regression testing hypothesis (2c).....	56

Regression testing hypothesis (2d).....	56
Hypothesis (3) and (3a)	57
Hypothesis (4) and (4a)	58
Hypothesis (5) and (5a)	59
Discussion.....	61
Limitations and Future Research.....	71
Conclusion.....	73
References.....	74
Appendices.....	112

List of Tables

<u>Table</u>		<u>Page</u>
1	Age, Gender, and Ethnicity Demographics	95
2	Percentage Data of Potentially Traumatic Events	96
3	Means, Standard Deviations, and Internal Consistencies for Dyadic Members.....	98
4	Bivariate Correlations of Study Variables for Young Adult Child Participants.....	100
5	Bivariate Correlations of Study Variables for Parent Participants	102
6	Bivariate Correlations of Study Variables Between Dyadic Members	104
7	Summary of Hierarchical Linear Regression Predicting Parent Posttraumatic Stress Symptoms	105
8	Summary of Hierarchical Linear Regression Predicting Parent Excessive Behaviors	105
9	Summary of Hierarchical Linear Regression Predicting Young Adult Child Posttraumatic Stress Symptoms.....	106
10	Summary of Hierarchical Linear Regression Predicting Young Adult Child Excessive Behaviors	107
11	Summary of Hierarchical Linear Regression Predicting Young Adult Child Experiential Avoidance.....	108
12	Summary of Hierarchical Linear Regression Predicting Young Adult Child Posttraumatic Stress Symptoms from Parent and Young Adult Child Variables.....	109
13	Summary of Hierarchical Linear Regression Predicting Young Adult Child Aggression	110

An Examination of Experiential Avoidance as a Vulnerability Factor for Posttraumatic Stress
Symptoms and Excessive Behaviors in Parent and Young Adult Child Dyads

Problem Statement

Posttraumatic Stress Disorder (PTSD) is classified in the DSM-IV-TR as an anxiety disorder that involves three symptom clusters: re-experiencing, avoidance and numbing, and hyperarousal. To meet DSM-IV-TR diagnostic criteria for PTSD, an individual must report experiencing a stressor (criterion A1) that involves exposure to a traumatic event in which he or she “experienced, witnessed, or had been confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of oneself or others,” and in which the reaction (criterion A2) involved intense feelings of “fear, helplessness, or horror” (American Psychiatric Association, 2000). However, revisions for diagnostic criteria were made in the DSM-5 to evaluate behavioral symptoms more closely, now including four symptoms clusters: re-experiencing, hyperarousal, avoidance and numbing, and negative thoughts and moods or feelings (American Psychiatric Association, 2013). The stressor or trigger criterion has been amended to constitute either actual or threatened death, sexual violation, or serious injury while criterion A2, formerly stipulating individual responses to the stressor, has been removed. Epidemiological research from the National Comorbidity Survey Replication (NCS-R) indicates over half of the general population, including men and women, reports having experienced a potentially traumatic event (PTE) at least once throughout the lifespan (Kessler et al., 2005). However, the lifetime prevalence rate for incidence of Posttraumatic Stress Disorder (PTSD) among adults is reported at only about 6.8% in the NCS-R. This finding very closely replicates the original National Comorbidity Survey (NCS), which indicated a lifetime

prevalence rate of approximately 7.8% for the general population (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995; NCS).

Due to this striking disparity between amount of trauma exposure and PTSD development, a common task of researchers in this area is the identification of psychological and behavioral risk factors that could predict PTSD symptomatology. Similarly and often in conjunction with this research, some scholars have adopted a focus on mechanisms that increase positive mental health outcomes following trauma exposure, or the absence of psychopathology despite incurring psychological harm, often referred to as psychological resilience or a related construct called posttraumatic growth (the ability to derive positive meaning following the experience of a distressing life event; Kashdan & Kane, 2010; Levine, Laufer, Stein, Hamama-Raz, & Solomon, 2009; Orzech, Shapiro, Brown, & McKay, 2009). At the center of these inquiries has been the study of emotion regulation approaches. Emotion regulation strategies, particularly experiential avoidance, are hypothesized by some researchers to partially or fully mediate the relationship between trauma exposure and the etiology of PTSD as well as a multitude of problem behaviors that could occur as a function of traumatic life events (e.g., Amstadter & Vernon, 2008; Barrett 2010; Kashdan & Kane, 2010; Kumpula et al., 2011; Reddy, Pickett, & Orcutt, 2006). Experiential avoidance, an unwillingness to interact with distressing or negative private experiences, is regarded as a functional response attained by engaging in a variety of topographically dissimilar problem behaviors (see Kingston, Clarke, & Remington, 2010).

Experiential avoidance and emotion regulation are conceptualized as learned behaviors or response styles (Chawla & Ostafin, 2007; Boulanger, Hayes, & Pistorello, 2010; Gross & Thompson, 2006). In particular, some of the problematic forms of experiential avoidance explicated are substance use and abuse, internet overuse, smoking, excessive exercise, repetitive non-suicidal self-injury, binge eating, and sexual promiscuity or risky sexual behavior (e.g., Batten, Follette, & Aban, 2001; Howe-Martin, Murrell, & Guarnaccia, 2012; Kingston et al., 2010; Levin, Lillis, Seeley, Hayes, Pistorello, & Biglan, 2012; Lillis, Hayes, & Levin, 2011). There are also different proposed types of experiential avoidance. Thought suppression is conceptualized as a form of experiential avoidance, while peritraumatic dissociation is also thought to carry some overlap (Marx & Sloan, 2005; Thompson & Waltz, 2010). Constructs related to experiential avoidance and emotion regulation include alexithymia, emotional inexpressivity, and avoidant coping (Berrocal, Pennato, & Bernini, 2009; Thompson & Waltz, 2010; Tull, Jakupcak, Paulson, & Gratz, 2007). Rumination is also postulated as a form of experiential avoidance, particularly depressive rumination (Giorgio, Sanflippo, Kleiman, Reilly, Bender, Wagner, Liu, & Alloy, 2010; Watkins & Nolen-Hoeksema, 2014).

One prominent finding throughout the emotion regulation literature is the importance of the family context in modeling and teaching emotion regulation strategies (Duncombe, Havighurst, Holland, & Frankling, 2012; McKee, Colletti, Rakow, Jones, & Forehand, 2008), including experiential avoidance. Consistent within this literature is the notion that children learn emotion regulation strategies from a young age and that parents play a vital role in fostering effective emotion regulation for their children. A major risk factor that has been associated with poor emotion regulation strategies and problem behaviors among children is parent psychopathology (Jaser, Fear, Reeslund, Champion, & Compas, 2008; Shea & Coyne, 2008).

The literature indicates that parent mental health status (predominantly maternal mental health) influences parenting trajectory, particularly if individuals do not seek mental health services (e.g., Coyne & Thompson, 2011).

The present study sought to integrate several areas of the research literature that have not been analyzed together. Experiential avoidance in parents was conceptualized as a vulnerability factor, distally impacting responding during exposure to PTEs, and influencing posttraumatic stress symptoms and excessive behaviors in parents. Parental modeling of experiential avoidance and excessive behaviors may impact child emotion regulation and influence similar outcomes among young adult children. Experiential avoidance may increase the severity of posttraumatic stress symptoms. Consequently, parent experiential avoidance, PTSD symptoms, and excessive behaviors may moderate the effect of young adult child experiential avoidance on negative outcomes. The present study endeavored to extend the parent-child emotion regulation and trauma literature by analyzing these variables in young adult children and their parents.

Review of the Empirical Literature

Emotion Regulation

Emotion regulation is encapsulated in a comprehensive framework and broadly defined as a controlled process involving the modification of emotions, in duration and intensity, and the conduct with which emotions are expressed, both consciously and nonconsciously (Gross, 1998). The emotion regulation construct is receiving increasing contemporary review (Koole, 2009; Sumida, 2011) and emotion dysregulation is a fundamental process targeted in modern behavior therapies such as Dialectical Behavior Therapy (DBT; Linehan, 1993), Mindfulness Based Stress Reduction (MBSR; Kabat-Zinn, 1982; 1990; 2003), and Acceptance and Commitment Therapy (ACT; e.g., Blackledge & Hayes, 2001). There are certain contextual features particularly essential to the study of emotion. These include situational antecedents, attention, appraisals, the concept of a multifaceted tendency in responding, and the malleable quality of emotions (Ekman, Friesen, & Ellsworth, 1972; Frijda, 1986, Levenson, 1994; Werner & Gross, 2009).

Mauss and colleagues (2005) define emotional experiences as complex occurrences constituting behavior, subjective experience, and physiological facets of the central and peripheral nervous systems. Gross (2006) discusses these features as comprised in a *Modal Model of Emotion*, which describes emotion antecedents and responses and the associations between them. The first key point is formulated around the idea that emotions may arise when a particular situation is appraised as pertinent to one's goals. In the final component, Gross argues emotions might be seen as compulsory (*control precedence*; Frijda, 1986) capable of interfering with or influencing behavior, and in contention with other responses. It should also be noted that the emotion regulation paradigm is distinguished from coping in that the objective of coping is to ameliorate negative affect and spans much longer in duration (Gross, 2006).

Emotion regulation appears to be a critical aspect of even the simplest human experiences and has been conceptualized as a continuous process (Gross, 2006). The *Process Model* of emotion regulation postulates there are five fundamental processes involved in emotion regulation. These include selection of the situation, modification of the situation, deployment of attention, changing of cognitions, and modulation of responses (Gross, 2006; Webb, Miles, & Sheeran, 2012). Further propelling the study of emotion regulation are *implicit* and *explicit* mechanisms (Gyurak, Gross, & Etkin, 2011). Implicit emotion regulation is thought to be an automatic process and typically studied from a neuropsychological paradigm (Kim & Hamman, 2007; Koole & Rothermund, 2011) while explicit emotion regulation is considered an effortful process (Mauss, Bunge, & Gross, 2007). Gyurak, Gross, and Etkin (2011) propose a continuum where implicit and explicit processes are interactive, arguing each concept as important to achieving emotion regulation.

Emotion regulatory strategies such as suppression may be successful in reducing negative emotion on an initial basis while they have been shown to be predictive of an increase in or maintenance of longer duration of negative emotions (e.g., Gross & John, 2003). Relatedly, problems with emotion regulation appear to be associated with psychopathology, problem behaviors, and poor mental health outcomes; in particular Borderline Personality Disorder (BPD) and negative affect, self-injurious behavior, alcohol-related disorders, substance abuse disorders, risky sexual behavior, and impulsivity (Fox & Linehan, 2007; Salsman & Linehan, 2012; Sher & Grekin, 2007; Tull, Weiss, Adams, & Gratz, 2012; Weiss, Tull, Viana, Anestis, & Gratz, 2012).

Although the empirical literature identifies emotion dysregulation as a central element in the etiology of poor psychological outcomes, a main limitation within this research is the expansiveness of the definition. In attempts to more discretely parse components of emotion

regulation, contemporary researchers are beginning to concentrate on emotion regulatory strategies. For example, a meta-analytic review by Aldao, Nolen-Hoeksema, and Schweizer (2010), examined acceptance, avoidance, problem solving, reappraisal, rumination, and suppression as emotion regulatory strategies associated with psychopathology. According to their review, internalizing disorders emerged as more strongly associated with these regulatory strategies than externalizing disorders.

The study of emotion regulation strategies is decidedly important. Mechanisms involved in emotion regulation warrant further study as certain regulatory strategies appear more effective than others. There is evidence to suggest emotions can be regulated in ways that are both helpful and productive while other regulatory strategies may be ineffectual or actually injurious (Gross, 2003). Accordingly, it may be useful to focus on emotion regulatory strategies, associated harmful consequences and links to resilience.

Experiential Avoidance

Foundations of a basic conceptual model for avoidance can be traced to Mowrer's two-factor theory of avoidance which proposes there are two integral components of avoidance behavior. First, a warning stimulus signals an aversive or anxiety provoking situation will momentarily transpire, based on a prior learning history of such, then an operant behavioral effort to intentionally evade the aversive stimulus is employed (Mowrer, 1951; Mowrer, 1956; Mowrer, 1960). The functional contextual movement conceptualizes avoidance behavior in terms of a functional class of behaviors termed *experiential avoidance*. Experiential avoidance is the unwillingness to withstand negatively appraised private events and subsequent efforts to escape or avoid such experiences (e.g., Hayes, Strosahl, Wilson, Bissett, Pistorello, Toarmino, Polusny, Dykstra, Batten, Bergan, Stewart, Zvolensky, Eifert, Bond, Forsyth, Karekla, & McCurry, 2004;

Hayes, Stroschal, & Wilson, 1999). The experiential avoidance construct is proposed as an approach to emotion regulation and a central process targeted in the ACT literature (Hayes, 1996; Hayes, 2004). The term encompasses experiential escape as well as experiential avoidance (Kanter, Baruch, & Gaynor, 2006).

The private events subsumed under experiential avoidance comprise thoughts, feelings, memories, as well as behavioral predispositions and contexts engendering them. Boulanger, Hayes, and Pistorello (2010) conducted a systematic literature review of experiential avoidance to discuss the evolution from *emotional* to *experiential* avoidance, concluding the latter encompasses a broader spectrum of the private events individuals may avoid. These include thoughts, physiological reactions, memories, action tendencies or urges, and even factual or concrete information should it challenge one's perception of self. Kashdan, Barrios, Forsyth, and Steger (2006) describe experiential avoidance as a *generalized psychological vulnerability*. In this line of thinking, there are certain circumstances in which experiential avoidance can be understood as adaptive. These circumstances include instances for which experiential avoidance is employed in a manner that still allows the pursuit of meaningful and valued goals. However, under the ACT model of human suffering, experiential avoidance, when relied upon in a rigid and inflexible manner, is deemed pathogenic (Boulanger, Hayes, & Pistorello, 2010). Also specific to ACT is the assumption that normal human functioning is understood as capable of leading to unhealthy outcomes, in contrast to more traditional cognitive-behavioral models of psychopathology (see Hayes, 2004; Biglan & Hayes, 1996). ACT assumes that behavior can function otherwise in certain domains, while still suitable to similar functional classes, and to attain behavioral change one must manipulate salient contextual factors (Murrell, Coyne, & Wilson, 2005).

ACT is grounded in Relational Frame Theory (RFT), a science of language and cognition which posits that language and higher cognition are shaped through bidirectional patterns of relational responding that may generalize to other relational frames (Hayes, Strosahl, Wilson, Bissett, Pistorello, Toarmino, 2004). Experiential avoidance is consequently hypothesized as a learned response style produced through verbal rules that generalize to other functional classes of behavior (Hayes, 1997). Boulanger, Hayes, and Pistorello (2010) recommend that while experiential avoidance is conceptualized as an emotion regulatory strategy, there may be more value in describing experiential avoidance as serving an emotion regulatory *function*. In this capacity, experiential avoidance could be a fundamental mechanism underlying emotion dysregulation. These researchers also discuss forms of emotion regulation such as cognitive reappraisal or suppression that could be maladaptive when engaged in as experiential avoidance.

Although experiential avoidance may be successful in reducing short-term psychological distress, like emotion dysregulation, rigid and over applications of this response style are linked with psychopathology across the spectrum. For example, the literature demonstrates experiential avoidance has associations with PTSD, depression, BPD, Social Anxiety Disorder (SAD), Generalized Anxiety Disorder (GAD), substance abuse disorders, and alcohol-related disorders (Giorgio et al., 2010; Iverson, Follette, Pistorello, & Fruzzetti, 2012; Lee, Orsillo, Roemer, & Allen, 2010; Levine, Lillis, Seeley, Hayes, Pistorello, & Biglan, 2012; Pepper, 2012; Thompson & Waltz, 2010; Wheaton, Berman, & Abramowitz, 2010). Experiential avoidance also appears to be a response style employed across cultures (Karekla & Panayiotou, 2011; Merwin, Rosenthal, & Coffey, 2009). Similar to emotion regulation, there are certain forms of experiential avoidance that seem particularly maladaptive. For example, the paradoxical effects of thought suppression, first noted in the renowned experiment by Wenzlaff and colleagues (1987), demonstrated how

participants instructed not to think about a white bear actually experienced increased thoughts of the white bear. Thought suppression has been identified as a prevalently employed form of experiential avoidance (Amstadter & Vernon, 2008; Thompson & Waltz, 2010).

While experiential avoidance might have certain distinctions from coping, (Karekla & Panayiotou, 2011) there may be theoretical overlap in the constructs. Karekla and Panayiotou (2011) found increased experiential avoidance was associated with self-distraction, seeking emotional support, denial, behavioral disengagement, self-blame, and venting. Less experiential avoidance was linked with positive reframing and acceptance. *Avoidant coping* refers to the tendency to purposely distract oneself, such as through watching television, when confronted with difficult emotions or experiences (Kashdan, Barrios, Forsyth, & Steger, 2006). Thus, some researchers conceptualize avoidant coping as a form of experiential avoidance (Thompson & Waltz, 2010). In contrast, experiential avoidance was shown to mediate the relationship between avoidant coping and chronic pain in a Portuguese sample (Costa & Pinto-Gouveia, 2011). The empirical literature is also beginning to examine experiential avoidance and *alexithymia*, the inability to describe or label one's emotions (Venta, Hart, & Sharp, 2012), within a similar framework, particularly in the context of traumatic life events (e.g., Thompson & Waltz, 2010). These researchers posit that alexithymia could serve as a form of experiential avoidance. Implications of the various proposed forms of experiential avoidance indicate this response style is wide-ranging and highlight the importance of further investigations.

Experiential Avoidance and Excessive Behaviors

Higher order factor-analytic research has demonstrated greater experiential avoidance predicts excessive engagement in problem behaviors and relationships among topographically dissimilar problem behaviors (Kingston et al., 2010). Explicitly, it was found that experiential

avoidance explained covariation between aggression, deliberate self-harm, internet overuse, sexual promiscuity, binge eating, restrictive eating, substance use, nicotine use, alcohol use, and excessive exercise. Collective in this area of research is the finding that individuals may report engaging in multiple problem behaviors. Kingston and colleagues' results suggest that a number of problem behaviors, regardless of form, could be explained as a result of a unifying functional pathway. For instance, research has shown that substance abusers are seven times more likely to develop a second addiction in comparison to non-abusers (Regier, Famer, Rae, Locke, Keith, Judd, & Goodwin, 1990). In another study, excessive urges and preoccupations to engage in Internet or computer use showed a prevalence rate of 1.5-8.2% among United States and European samples surveyed (Weinstein & Lejoyeux, 2010). It was also found that parenting and familial factors, personality traits, alcohol use, and social anxiety served to predict Internet overuse. Cooper, Wood, Orcutt, and Albino (2003) hypothesized that risky or problematic behavior could be explained by a single higher order latent variable, as the experience of negative emotion commonly occasions such behavior. Avoidance coping was found to prospectively predict engagement in sexual behavior, educational underachievement, substance use, and delinquency in a sample of Black and White adolescents. The relationship between problem behaviors and experiential avoidance and dysfunctional emotional regulation strategies suggests that experiential avoidance is a key mechanism through which various excessive problem behaviors emerge.

As such, the topography of the behavior may not necessarily be a useful focal point within therapy. Rather, interventions might address the function of the behavior (Mansell, Harvey, Watkins, & Shafran, 2009). The transdiagnostic research, in particular, seeks to substantiate experiential avoidance as a common functional pathway for a variety of poor mental

health outcomes and problem behaviors (Boulanger, Hayes, & Pistorello, 2010; Chawla & Ostafin, 2007). Psychological or distressing situational challenges and difficulty adjusting to or transcending such situations could be explained at least partially by experientially avoidant response styles (Zettle, Peterson, Hocker, & Provines, 2007; Zettle, Barner, Gird, Boone, Renollet, & Burdsal, 2012). Therefore, individuals who have an increased propensity to engage in experiential avoidance may be more likely to engage in excessive problem behaviors in contexts that engender distressing private events.

Parent-Child Emotion Regulation and Experiential Avoidance

Socialization has been highlighted as an important process in teaching children self-regulation of emotion, and parent coaching in capacities such as empathy and validating emotion could be essential skills required for understanding and managing emotion (Duncombe, Havighurst, Holland, & Frankling, 2012). These researchers also emphasize that parents may serve to reinforce the expression of emotion. Therefore, parents who are particularly minimizing or punitive may inadvertently foster poor emotion regulatory strategies in their children. Sheffield Morris and colleagues (2007) discuss a tripartite model through which children learn emotion regulation; 1) children may learn about emotion regulation through observation, 2) parenting practices or behaviors that may relate to the socialization of emotion affect emotion regulation, 3) emotion regulation may be affected by the emotional climate of the family. That is, emotion regulation is affected through factors such as the quality of attachment relationships, parenting styles, family expressiveness and the emotional quality of the marital relationship.

Hubbard and Dearing (2004) discuss a model of *Affective Social Competence* (ASC). The ASC involves the process of sending, experiencing, and receiving messages pertaining to emotions. This process is conceptualized as a continuous interaction between children and their

peers and how they develop a sense of self, within this context. Models for parent-child emotion regulation highlight the impact of parent coaching on the malleability of children's emotion regulation. Similarly, scholars are beginning to examine the role of experiential avoidance within the parent-child relationship. For example, it has been postulated that parents who respond with experiential avoidance while observing their child engage in behavior indicative of negative private experiences are more likely to exert higher degrees of control or be more intrusive in their children's interactions (Tiwari, Podell, Martin, Mychailyszyn, Furr, & Kendall, 2008). Greco and Eifert (2004) contend acceptance may be a crucial component in parent-child therapy, proposing an integrative family therapy. They suggest more traditional change-oriented therapeutic approaches, such as problem-solving/communication training (PS/CT) and behavior management training (BMT), could be enhanced through integrating the concept of acceptance. The role of experiential avoidance and values orientation within the family are also identified as important aspects of the therapeutic environment.

Relatedly, Coyne and Wilson (2004) suggest that *cognitive fusion*, the notion that thoughts are no different from literal reality (thought to underlie experiential avoidance), is a crucial factor in impaired parenting. Coyne, McHugh, and Martinez (2011) reviewed the literature pertaining to ACT constructs that include experiential avoidance, acceptance, and mindfulness within work with adolescents. In particular, they discuss the link between parent experiential avoidance and child emotional and behavioral functioning. A *Model for Mindful Parenting* has also been proposed, theorizing that employing mindfulness as a component of parenting practices will allow parents to evaluate their parenting experience in the context of the relationship with their child (Duncan, Coatsworth, & Greenberg, 2009). This model postulates

that parents who learn or have a proclivity for mindfulness could create a family environment that leads to increased satisfaction within the parent-child relationship.

The empirical literature also supports some of the hypotheses proposed in the various models of parent-child emotion regulation, discussed above. Robinson and colleagues (2009) used a parent-child interaction task with a group of maltreated children in out of home care and their parents and compared these data with that derived from a control group of non-maltreated children. Their findings demonstrated maltreated children displayed more anger, internalizing symptoms, and less positive affect than the non-maltreated group of children. Emotion dysregulation was also associated with internalizing symptoms and parent positive affect was associated with lower levels of child internalizing symptoms, while parent anger was associated with higher internalizing symptoms. Experiential avoidance has also been examined among mothers of pre-term infants. Results of this study showed that experiential avoidance, relationship satisfaction, prenatal expectations, and postpartum support served to predict maternal attachment, psychological symptoms and responsiveness, with experiential avoidance emerging as the strongest predictor (Evans, Whittingham, & Boyd, 2012). Experiential avoidance and cognitive fusion in parents of children with Autism Spectrum Disorders (ASD) were investigated in another study. An ACT intervention was employed, and overall, the intervention reduced both processes in parents.

Amble (2011) evaluated parent-adolescent relationships on levels of experiential avoidance. Significant in these findings was the result that experiential avoidance was related to depression and anxiety; however, experiential avoidance did not mediate the association between attachment security and internalizing symptoms. Shea and Coyne (2011) investigated the relationships between maternal dysphoria, parenting stress, and experiential avoidance as risk

factors for ineffective parenting in a high-risk population. Results of hierarchical multiple regression analyses showed that parenting stress predicted inconsistent parenting and punitive parenting over and above depression, child behavior problems, and experiential avoidance. These findings illustrate the potential impact of mothers' avoidant regulatory strategies upon young children and highlight the notion that parents may fail to teach children skills to effectively communicate distressing private events.

Effects of Parent Psychopathology on Child Emotion Regulation

Parent mental health may also impact substantively upon child emotional understanding and emotion regulation (Brennan, Le Brocque, & Hammen, 2003; Duncombe et al., 2012). One of the most salient findings in the parent-child emotion regulation literature includes the premise that parent psychopathology serves as a significant risk factor for poor self-regulatory strategies in children (e.g., Jaser et al., 2008; Robinson, Morris, Heller, Scheeringa, Boris, & Smyke, 2009; Shea & Coyne, 2011). Coyne and Thompson's (2011) examination of a population of low socioeconomic status mothers and their preschool children, reports that mothers who conveyed more depressive symptoms also recounted stronger feelings of being out of control in parenting situations as well as greater experiential avoidance. Parent psychopathology also appeared to be an important factor in parent-child emotion regulation among a sample of Japanese mothers and their children (Shimabukuro, 2010). In an investigation of parent-adolescent attachment relationships, Amble (2011) found experiential avoidance was significantly related to depression and anxiety in both parents and adolescents. These findings provide evidence in several key areas. Parent experiential avoidance could exacerbate or interact with parent psychopathology and as such, impact upon child emotion regulation through a lack of, or an inappropriate means, of socializing emotional understanding.

Parent Experiential Avoidance

Parent experiential avoidance has been delineated as a process in which a parent observes his or her child's apparent experiences of emotionally arousing incidents, and then interferes in attempts to alter the child's experiences (Cheron, Ehrenreich, & Pincus, 2009). However, more ambiguous is the distinction between whether parent experiential avoidance pertains more to the parent's unwillingness to contact their own private events, their child's, or some integration of both components. Tiwari and colleagues (2008) assert that parent experiential avoidance could produce child psychopathology, such as anxiety, through consistently interfering with the child's behavior. It has been further proposed that assessment of experiential avoidance in the context of parenting should involve a separate measure of parental private events in relation to their child's (Cheron et al., 2009). The Parent Acceptance and Action Questionnaire (PAAQ) may more appropriately address the construct of parent experiential avoidance, and is increasingly being utilized (Cheron et al., 2009; Shea & Coyne, 2011).

The relationships between maternal depression, parent-child relations, and resilient outcomes among adolescents in Australia were examined using the Five-Minute Speech Sample monologue paradigm, a child self-report questionnaire of maternal warmth and hostility, and a measure involving child reporting of parent behavior (Brennan et al., 2003). Lower levels of parental psychological control, higher levels of maternal warmth, and lower levels of maternal over involvement interacted with maternal depression and predicted resilient outcomes in 15-year-old adolescents and their maternal parents. Paternal psychiatric status also appeared to influence resilient outcomes. In sum, this literature points to an increasing need to understand experiential avoidance in the context of parenting as well as factors that may contribute to such a repertoire.

Parent-Child Experiential Avoidance and Excessive Behaviors

Parents who engage in disproportionate experiential avoidance may model this response style for their children and thus influence internalizing and externalizing trajectories. For example, coercive parenting practices may be a risk factor for child externalizing behaviors (McKee et al., 2008). Specifically, poor parenting practices could increase children's noncompliant behaviors, such as parents failing to follow through with a command, thus negatively reinforcing noncompliance in varying topographies. Hubbard and Dearing (2004) have further conceptualized emotional understanding and emotion regulation in children as linked with problem behaviors and this theory is supported in the literature. For instance, Coyne and Thompson (2011) found that preschool children of mothers reporting greater experiential avoidance and depression evidenced more internalizing symptoms. Results of another study showed that children's perceptions of attachments to mothers and fathers predicted behavioral, social, and cognitive problems, and moderated the relationship between parental problem drinking and child functioning (El-Sheikh & Buckhalt, 2003). Correspondingly, higher levels of family cohesion and adaptability appeared to serve as protective factors against adjustment and cognitive difficulties from problem drinking. These results highlight the important influence the parent-child relationship and modeling of problem behaviors could have upon child behavioral, cognitive, and social functioning.

Avoidance has been conceptualized in another framework, using Linehan's theory of an invalidating environment (Rosenthal, Polusny, & Follette, 2006), wherein it was postulated that gender differences might exist between males and females on measures of experiential avoidance. Specifically, it was theorized that mothers may be more affectively positive when interacting with daughters as compared to sons, consequently modeling that it is unacceptable to

experience certain distressing or negative emotions. Based on this theory, a sample of women was used to explore the relationship between perceived criticism in the family of origin and psychological distress in adulthood/adjustment as mediated by avoidance. Baron and Kenny's (1986) mediational models showed that experiential avoidance mediated the proposed relationship. This finding, coupled with the hypothesis that parent experiential avoidance contributes to the maintenance of child internalizing behavior (Tiwari et al., 2008) bolsters the hypothesis that environmental factors such as parent emotion regulatory strategies could distally predict poor mental health outcomes and problem behaviors in their young adult children.

Externalizing and internalizing behavior problems in children were further associated with poor maternal emotion regulation among a Japanese sample (Shimabukuro, 2010). Parent emotional expressivity, child effortful control, and child behavioral problems have been conceptualized as acquired in a bidirectional process through parent-child interactions and denoted as *emotionally relevant socializing behaviors* (Valiente, Eisenberg, Spinard, Reiser, Cumberland, Losava, & Liew, 2006). Longitudinal data analyses in this study suggested that children's effortful control mediated the relationship between maternal expressivity and children's internalizing problems, but not so for externalizing problems. These findings illustrate movements toward more fully considering the relationships between emotion regulation and behavior problems in parent-child relationships. However, associations between parent-child experiential avoidance and subsequent behavior problems in children have not been clearly elucidated. Examining the impact of experiential avoidance on these outcomes is therefore an area that will advance the research literature.

The impact of parental excessive behaviors on child mental health was investigated (Keller, Cummings, Davies, & Mitchell, 2008) in a longitudinal study of relations between

maternal and paternal problem drinking symptoms, destructive marital conflict, parenting problems, and children's internalizing and externalizing problems among community families with kindergarteners. Structural Equation Modeling (SEM) demonstrated parent problem drinking was associated with increased destructive marital conflict at a one-year follow up session. Destructive marital conflict was related to diminished parental warmth and increased parent psychological control. Parenting problems were associated with greater child internalizing and externalizing problems at another follow up, and the indirect effects of parent drinking on children adjustment were significant. This literature demonstrates the deleterious impact of emotion regulation difficulties within the family context and problem behaviors that may occur as a result.

Harmful Sequelae of Trauma Exposure

Exposure to trauma is predictive of a host of negative psychological and behavioral outcomes. PTSD is the most prevalent psychopathology following trauma exposure (Kessler et al., 2005) and research suggests that female participants are more likely to develop PTSD than male participants (Tolin & Foa, 2006). One study evaluated the impact of recent life events, chronic strains, and social support on symptoms self-reported for individuals exposed to trauma (Ullman & Siegel, 1993). Findings showed that trauma exposure was associated with younger age in general, decreased level of educational achievement, recent occurrence of life events, and prior history of psychiatric disorders. Risk of increased posttraumatic stress was linked with sexual assault, other life events, and household strain. Greater symptoms of PTSD were found among women and younger participants. These results and similar risk factors associated with trauma have been replicated in more recent research. Specifically, risk factors evaluated in one meta-analysis included the female gender, greater social, educational, and intellectual

shortcomings, psychiatric history, and previous exposure to trauma (Brewin, Andrews, & Valentine, 2000). Trauma exposure is also highly predictive of depression, substance abuse, Borderline Personality Disorder, and somatization symptoms (Breslau, 2001; Ehring, Frank, & Ehlers, 2008; Flood, McDevitt-Murphy, Weathers, Eakin, & Benson, 2009; Iverson et al., 2012). Creamer, McFarlane, and Burgess (2005) noted that experiencing powerful emotions during trauma exposure was associated with increased PTSD symptomatology and other psychiatric disorders, and they concluded that traumatic memories could mediate this relationship. However, it would be interesting to explore emotion regulation as a possible mediating and moderating factor in addition to traumatic memories.

Consequences of trauma exposure for children. Although the literature displays consistent harmful consequences related to trauma exposure, there is a paucity in empirical studies of trauma sequelae in children and adolescents. The empirical literature that does address sequelae of childhood trauma exposure generally establishes that children exposed to trauma are at risk for psychological, behavioral, and neurobiological issues and that social support may be a critical protective factor influencing the development of PTSD in children (Caffo, Forresi, & Lievers, 2005; Polusny, Ries, Meis, DeGarmo, McCormick-Deaton, Thuras, & Erbes, 2011).

Although childhood trauma is well linked with child psychopathology, the underlying mechanisms or mediating factors are ambiguous (Vostanis, 2004). BPD is one prevalent outcome following childhood trauma exposure, especially in women (Smith, 2006). Indeed, Smith suggests that the prevalence of sexual assault in women with BPD indicates this type of traumatic event could contribute to the etiology of BPD. Childhood trauma may also be linked with the emergence of depression in adulthood (Heim, Newport, & Mletzko, 2008). In another study using data from the NCS, childhood physical abuse, sexual abuse, and neglect were related

to risk for physical illnesses in adulthood (Goodwin & Stein, 2004). Trauma exposure in children and adolescent is also a predictor of somatic symptoms (Kugler, Bloom, Kaercher, Truax, & Storch, 2012).

These findings synthesize the limited evidence on children's reactions to trauma. Therefore, it is imperative to enhance knowledge of factors that contribute to trauma-related outcomes for children and their families. As a consequence of the robust relationship between trauma exposure and poor psychological outcomes, and the epidemiological research concerning lifetime PTSD prevalence rates for men and women, researchers investigating risk factors for PTSD are beginning to focus on emotion regulation processes. Emotion regulation, particularly experiential avoidance, may be the missing link in the development and maintenance of this outcome variable.

The Role of Experiential Avoidance in Posttraumatic Stress Disorder

Avoidance symptoms comprise cluster C for a PTSD diagnosis in the DSM-5 (American Psychiatric Association, 2013). Accordingly, researchers are adopting a conceptualization of PTSD avoidance symptoms within the framework of experiential avoidance (e.g., Kumpula et al., 2011; Orcutt, Pickett, & Pope, 2005; Plumb, Orsillo, & Luterek, 2004; Thompson & Waltz, 2010). The body of research examining experiential avoidance as a maladaptive regulatory style subsequent to trauma appears to be gradually aggregating. As experiential avoidance is considered a transdiagnostic process (Mansell, Harvey, Watkins, & Shafran, 2009), adopting this framework points in the direction of concentrating on functional processes involved in PTSD as opposed to the medical model's traditional focus on the topography of a diagnostic construct. DSM-IV-TR criteria for PTSD states that symptoms must have occurred in the past month (American Psychiatric Association, 2000), although certain diagnostic measures of PTSD such

as the Clinician-Administered PTSD Scale for DSM-IV (CAPS) also assess for lifetime presence of symptoms (Weathers, Keane, & Davidson, 2001). As it is imperative for individuals to receive treatment ensuing distressing life events regardless of diagnostic qualification status for PTSD, a transdiagnostic conceptualization is warranted.

In another study, experiential avoidance mediated the effects of PTSD on quality of life in Albanian survivors of the Kosovo War (Kashdan, Morina, & Priebe, 2009). Similarly, Plumb, Orsillo, and Luterek (2004) presented the results of three studies, two involving convenience samples and the third involving a clinical sample of male veterans. Experiential avoidance predicted distress in the first convenience sample. It was associated with PTSD symptom severity and general psychopathology and predicted total PTSD symptom severity over and above trauma severity in the second sample. In the clinical sample, experiential avoidance was the strongest predictor of distress, controlling for previous distress symptomatology as well as severity of traumatic event. Furthermore, Tull, Jakupcak, Paulson, and Gratz (2007) revealed that experiential avoidance and emotional inexpressiveness explained unique variance in aggressive behavior, over and above PTSD symptom severity and trait anger in a sample of men exposed to interpersonal violence. These studies provide important evidence for experiential avoidance as one key factor through which PTSD symptoms could be exacerbated.

Another type of traumatic event commonly linked with experiential avoidance is both sexual and physical victimization. Rosenthal, Rasmussen Hall, Palm, Batten, and Follette (2005) used a sample of undergraduate females to investigate chronic engagement in experiential avoidance as a mediating factor between childhood sexual abuse and psychological distress in adulthood. Consistent with hypotheses, experiential avoidance mediated this effect. These results are similar to the finding that experiential avoidance mediated the relationship between sexual

victimization before age 18 and psychological functioning in adulthood in undergraduate females (Marx & Sloan 2002; Polusny, Rosenthal, Aban, & Follette, 2004). Comparably, the interrelationship between child and adult sexual victimization, alcohol use, and high risk sexual behavior were evaluated with experiential avoidance entered as a mediator (Polusny, 1998). History of childhood and adolescent victimization and higher levels of distress influenced experiential avoidance, while experiential avoidance was linked with high-risk sexual behavior and PTSD avoidance symptoms. A direct path was found between adult sexual victimization and alcohol use. Emotion dysregulation was also found to have an indirect effect on sexual victimization and sexual revictimization among childhood sexual abuse survivors as well as childhood physical abuse survivors (Messman-Moore, Walsh, & DiLillo, 2010). It also predicted lifetime number of sexual partners and frequency of risky sex with a stranger as well. Hence, emotion dysregulation could be a distal predictor and risky sex may be a more proximal predictor of revictimization.

Relatedly, experiential avoidance was significantly related to reports of childhood trauma in an adult homeless population (Barrett, 2010). Specifically, experiential avoidance and emotional nonacceptance were associated with moderate to severe sexual, physical, and emotional abuse compared to individuals reporting no abuse or lower rates of abuse. Furthermore, emotional nonacceptance mediated the relationship between childhood abuse and experiential avoidance for emotional abuse. These findings suggest that emotional nonacceptance is a mechanism through which emotional abuse leads to experiential avoidance (Gratz, Bornovalova, Delany-Brumsey, Nick, & Lejuez, 2007).

Experiential avoidance and peritraumatic dissociation. Experiential avoidance and related constructs are receiving considerable study as contributing factors for symptomatology

associated with PTSD. Peritraumatic dissociation refers to a dissociative response that occurs during a traumatic event. It is perceived to be an integral aspect of responses to trauma, and although a link between peritraumatic dissociation and PTSD has been identified, researchers are unclear of the mechanisms of action involved in this relationship (Marx & Sloan, 2005). Some researchers conceptualize peritraumatic dissociation as a form of experiential avoidance (see Hayes, Wilson, Gifford, Follette, & Strosahl, 1996; Polusny & Follette, 1995) and there is evidence to advise that peritraumatic dissociation is a vulnerability factor for PTSD (e.g., Marshall & Schell, 2002). As both experiential avoidance and peritraumatic dissociation predict PTSD, researchers are beginning to suspect there is some overlap between constructs. For example, one prospective investigation among female undergraduate students revealed that experiential avoidance longitudinally predicted peritraumatic dissociation and posttraumatic stress symptoms at the time of a mass college campus shooting (Kumpula et al., 2011). These results augment the hypothesis that experiential avoidance could contribute to the development and maintenance of posttraumatic stress symptoms across time.

Peritraumatic dissociation has also been investigated as a proxy risk factor for experiential avoidance as associated with PTSD (Marx & Sloan, 2005). Peritraumatic dissociation and experiential avoidance were significantly related to PTSD at baseline, but once controlling for levels of PTSD, only experiential avoidance was associated with PTSD symptoms at both 4 and 8 week follow-up. Therefore, peritraumatic dissociation may not be a proxy risk factor for experiential avoidance, but more independently related to PTSD. It may even be conceptualized as adaptive under certain circumstances. However, the limitations of current trauma and experiential avoidance literature are the cross-sectional nature of most studies,

making it difficult to determine the extent to which constructs overlap or set the stage for one another.

Another investigation examined experiential avoidance as a risk factor for PTSD symptoms over and above combat exposure, perceived life threat, peritraumatic dissociation, recent life stress, perceived postdeployment social support, and personality in a sample of war veterans (Meyer, Morissette, Kimbrel, Kruse, & Gulliver, 2013). Half of participants ($n = 109$) met PTSD criteria. Results indicated that experiential avoidance explained unique variance in PTSD symptom severity controlling for all other predictor variables, with small effect sizes on the CAPS and large effect size on self-report instruments of PTSD. Additionally, the effects of experiential avoidance on PTSD were still significant when controlling for PTSD avoidance symptoms. Overall, experiential avoidance may serve as a mechanism for peritraumatic dissociation, and thus contribute to PTSD symptoms through experiential avoidance as a distal factor. However, it could also be speculated that peritraumatic dissociation moderates the effect of experiential avoidance on PTSD.

Experiential avoidance, thought suppression, and alexithymia. There is an emerging need to more fully understand certain core processes in experiential avoidance both theoretically and empirically. Such understanding will foster a more explicit operational definition of experiential avoidance and facilitate incremental validity with regards to alternate constructs (Chawla & Ostafin, 2007). Thought suppression has been studied as a form of experiential avoidance and predictor of PTSD symptomatology. To illustrate, Amstadter and colleagues (2008) examined adaptive emotion modulation strategies in the form of emotion reappraisal and emotion suppression, unique variance explained by these strategies as predictors of anxiety, depression, and PTSD, and the role of thought suppression in PTSD among participants with

PTSD compared to a control group with no PTSD. Thought suppression was the only significant predictor of PTSD while avoidant coping marginally predicted anxiety, controlling for thought suppression. Another study examined the relationships between PTSD, childhood trauma and alexithymia among outpatients (Zlotnick, Mattia, & Zimmerman, 2005). PTSD and BPD were found to make unique contributions to higher reports of alexithymia and greater emotional neglect was associated with higher alexithymia. Interestingly, BPD was most strongly associated with alexithymia.

Mindfulness, experiential avoidance, thought suppression, alexithymia, and avoidant coping were evaluated as predictors of PTSD avoidance symptom severity (Thompson & Waltz, 2010). Greater levels of experiential avoidance predicted greater PTSD avoidance symptom severity while greater mindfulness predicted lower PTSD avoidance symptom severity above and beyond experiential avoidance measures (including thought suppression, alexithymia, and avoidant coping). Therefore, experiential avoidance could be a central process that predicts mental health outcomes following trauma. In another study, Tull, Gratz, Salters, and Roemer (2004) explored relationships among experiential avoidance, thought suppression, PTSD symptom severity, and symptoms of depression, anxiety, and somatization among individuals exposed to multiple traumatic events. Experiential avoidance was not associated with severity of PTSD beyond a shared association with general psychiatric symptom severity, but was associated with depressive symptoms, anxiety, and somatization when controlling for PTSD symptom severity. Controlling for PTSD symptom severity, it was found that thought suppression was associated with PTSD symptom severity. This suggests an important impact of different forms of experiential avoidance on PTSD.

Experiential avoidance, trauma exposure, and the family context. In the context of family relationships, there is literature to support experiential avoidance as a risk factor for PTSD development and internalizing/externalizing outcomes in children. For example, experiential avoidance was associated with PTSD in maltreated adolescents (Shenk, Putnam, & Noll, 2012). Reddy, Pickett, and Orcutt (2006) tested the hypothesis that childhood psychological abuse is related to current psychological distress through experiential avoidance in college students. Findings elucidated that experiential avoidance mediated the proposed relationship. Childhood psychological abuse history was related to experiential avoidance and current mental health symptoms. Experiential avoidance was also associated with mental health symptoms.

Lieberman, Van Horn, and Ozer (2005) hypothesized that mothers of children who witness marital violence might be at risk for overlooking the importance of teaching effective emotion regulation to children. Children may be more vulnerable to imitating aggressive behaviors they witnessed resulting in internalizing or externalizing behaviors. Therefore, mothers' lifetime stress was conceptualized as a risk factor for child behavior problems. In this conceptual model, the greater the mothers' cumulative stress, the greater the associated child behavior problems. Quality of the parent-child relationship and maternal PTSD mediated the relationship between maternal life stress and child behavior problems.

Koverola, Papas, Pitts, Murtaugh, Black, and Dubowitz (2005) proposed that interpersonal victimization has long-lasting consequences which interfere with parenting capacity and found maternal victimization history was associated with child internalizing and externalizing behavior problems and lower levels of child socialization. In another study, Samper, Taft, King, and King (2004) investigated associations between PTSD symptoms and its

clusters with self-reported parenting satisfaction among Vietnam veterans. Avoidance and emotional numbing were most strongly associated with lower parenting satisfaction, while PTSD symptom severity was negatively correlated with parenting satisfaction. Individuals with heightened PTSD symptoms and avoidance and emotional numbing may therefore be more at risk for reporting poor parenting satisfaction.

Scaramella, Sohr-Preston, Callahan, and Mirabile (2008) discussed the *Family Stress Model*, which postulates that economic pressures weaken parent mental health, and parenting and child adjustment as a concern. In a sample of low-income mothers and toddler children pre and post Hurricane Katrina, family financial strain, maternal depressive symptoms, parenting efficacy, and child problem behaviors were associated, and neighborhood violence were associated with higher levels of mothers' depression. However, these variables did not differ across time. Thus, parent psychopathology could be a major risk factor for a host of psychological and behavioral problems among families experiencing stress related to trauma exposure. In a sample of 35 mother-child dyads from a shelter, the short-term effects of child internalizing trajectories after Intimate Partner Violence (IPV) exposure was assessed (Gewirtz, DeGarmo, & Medhanie, 2011). Indicators of internalizing symptoms for children exposed to trauma could include characteristics of the events such as the degree or extent of exposure, and family and environmental support. Results demonstrate that parenting is an important protective factor for children in the immediate aftermath of a traumatic event, even in circumstances in which the parent was victimized. Moreover, mothers' parenting practices influenced children's recovery following witnessing IPV and maternal distress was associated with child internalizing, and child trauma-related distress was associated with parenting. Another study analyzed trauma exposure in parents and PTSD in relation to emergence of PTSD, depressive and anxiety

disorders in a sample of Holocaust survivors (Yehuda, Halligan, & Bierer, 2001). Stepwise logistic regression analyses demonstrated a relationship between parental PTSD and a PTSD trajectory in their children. Parental trauma exposure predicted lifetime depressive disorder above and beyond parental PTSD.

The experimental foundation for the present study is an investigation of experiential avoidance as a mediating factor between family disaster exposure and adolescent PTSD symptomatology (Polusny et al., 2011). These authors discuss ACT theory, in which it is postulated that adolescents learn experiential avoidance through modeling, family processes, or poor parenting practices. Disaster exposure was associated with higher levels of experiential avoidance in both parents and adolescents exposed to a series of severe tornadoes. Experiential avoidance predicted PTSD in both adolescents and parents and parent PTSD symptoms predicted adolescent PTSD. Furthermore, parent PTSD moderated the effect of adolescent experiential avoidance on adolescent experiential avoidance and adolescent PTSD, but parent experiential avoidance was not a significant moderator. Parent trauma exposure and experiential avoidance appear to be important factors influencing these variables in adolescents, especially if parents are the primary modality of support following trauma.

Psychological Resilience and Emotion Regulation

A separate paradigm from risk factors for poor psychological outcomes is the converse, which seeks to investigate protective factors or psychological resilience. Bonanno (2005) delineated resilience as the maintenance of a customary balance in the wake of severely disparaging conditions. The overlap between psychological resilience and emotion regulation has been unified into a *Broaden-and-Build Theory of Positive Emotions* (Tugade, & Frederickson, 2004). In this model, positive and negative emotions are comprised of distinct and

complementary adaptive functions. They also are anticipated to contribute to cognitive and psychological effects. This theory of resilience and emotion regulation may further explicate why individuals who experience positive emotions during a stressful event successfully regulate negative emotional experiences.

In consideration of this theory, laboratory investigations were conducted by Tugade and Frederickson (2004) during which participants were instructed they had 60 seconds to prepare a three-minute speech. Higher resilience was associated with more happiness and higher trait resilience with lower appraisal of threat. Trait resilience was also negatively correlated with cardiovascular reactivity, and positive emotionality mediated the relationship between resilience and cardiovascular reactivity. Such an investigation provides impetus for further psychological resilience and emotion regulation studies.

Positive emotion focused coping processes such as cognitive reappraisal and problem-focused coping could mitigate the negative effects of life stressors (Folkman & Mosowitz, 2000), as these regulatory strategies often stimulate positive emotion. Thus, the willingness to experience both positive and negative emotions during stressors may facilitate a strong capacity for resilience. Conversely, it should follow that individuals who deliberately act to alter emotional experiences limit the ability to experience positive emotions through attempts to evade negative emotion. Experiential avoidance could plausibly limit psychological resilience. The robust connection between experiential avoidance and PTSD, which involves stressors by definition, bolsters such a conceptualization.

More ambiguous within the resilience literature is the uncertainty as to whether the construct should be viewed as a process or an outcome variable (Thompson, Arnkoff, & Glass, 2011). Some of the main factors isolated as promoters of psychological resilience include

individual characteristics such as hardiness, locus of control, social support, coping, optimism (Ryan & Calabiano, 2009), and self-compassion (Neff & McGehee, 2010). There may be different types of resilience, and therefore no one way by which to achieve resilience (Bonanno, 2005).

Trait mindfulness and acceptance are also conceptualized as components of psychological resilience (Thompson et al., 2011). These researchers discuss implications of findings that individuals higher in levels of mindfulness and acceptance prior to experiencing traumatic stressors may show improved outcomes compared to those who are not. They further argue that trait mindfulness and acceptance promote positive psychological outcomes following trauma. This may be particularly relevant as experiential avoidance is conceptualized as the inverse or antithesis of the mindfulness construct (Mitmansgruber, Beck, Höfer, & Schüßler, 2009). Thompson and colleagues (2011) further contend that mindfulness and acceptance contrast with experiential avoidance or peritraumatic dissociation and coping strategies such as emotional disengagement, which may occasion heightened PTSD. Adopting such a theory could be useful as experiential avoidance is hypothesized to contribute to PTSD.

Experiential avoidance has been tested as moderator of posttraumatic stress symptoms following the experience of traumatic events (Kashdan & Kane, 2010). Findings suggest that in the presence of experiential avoidance, posttraumatic distress was linked with less posttraumatic growth, but when experiential avoidance was not present, distress was linked with greater growth. Furthermore, the interaction between experiential avoidance and posttraumatic distress predicted meaning in life and in the presence of experiential avoidance, posttraumatic distress was associated with less meaning in life. Therefore, post trauma exposure, individuals who

experience more distress but rely less on experiential avoidance may report more growth and meaning in life.

Experiential avoidance and forgiveness were analyzed together in the same model as predictors of PTSD in the context of interpersonal trauma exposure among an undergraduate sample (Orcutt, et al., 2005). Both experiential avoidance and forgiveness partially mediated the relationship between traumatic interpersonal events and PTSD symptoms, in the anticipated directions. Although not explicitly theorized as such in the model, forgiveness following such transgressions could serve to increase positive emotion in the wake of subsequent stressors. According to the *Broaden-and-Build* theory, forgiveness may also operate as a component of either psychological resilience, posttraumatic growth, or some constituent of these constructs.

There is also empirical support for interventions incorporating mindfulness to improve emotion regulation and mitigate symptoms associated with PTSD. In one clinical case study, mindfulness training increased emotion regulation skills during Prolonged Exposure (PE) for an adolescent female who reported experiencing a sexual assault (Frye & Spates, 2012). Kearney, McDermott, Malte, Martinez, and Simpson (2012) looked at outcomes among veterans enrolled in Mindfulness Based Stress Reduction (MBSR). PTSD, depression, functional status, behavioral activation, experiential avoidance, and mindfulness were examined at baseline and at two and six months following enrollment. The latter follow-up found significant improvement in PTSD symptoms, depression, and behavioral activation, a mental component summary score, acceptance, and mindfulness. It is also noteworthy that 47.7% of the sample showed clinically significant improvements in PTSD symptoms. Such a program's efficacy in the reduction of experiential avoidance and PTSD symptoms, in particular, corroborate the role of mindfulness in improving mental health outcomes and could prospectively increase resilience in the wake of

further trauma. Finally, it has been asserted that mindfulness and acceptance could serve to bolster resilience in parents and children following trauma (Polusny, Ries, Meis, DeGarmo, McCormick-Deaton, Thuras, & Erbes, 2011). In the family context, resilience from trauma promoted through strong familial support may operate as a robust protective mechanism.

Rationale and Hypotheses

In the developing body of research examining the interaction between parent and child emotion regulation processes, there is a need to more fully elucidate risk factors for the development of a maladaptive experiential avoidance repertoire. It is also essential to expound on factors that could contribute to or buffer the manifestation of posttraumatic stress symptoms and excessive problem behaviors. The present study aimed to extend the current empirical literature by evaluating a conceptual model in which parental experiential avoidance and reports of trauma exposure, posttraumatic stress symptoms, and excessive behaviors were predicted to interact with these variables in their young adult children. This study built upon the only known study examining parent and adult child experiential avoidance data (Sabo & Loverich, manuscript in preparation). It also sought to examine the influence of traumatic life events incurred by both parents and young adult children to better understand if these events impacted the amount and degree of excessive behaviors reported as well as posttraumatic stress symptom severity.

This study bridged a series of inductive hypotheses with a goal of increasing understanding of the relationship between parent and young adult child emotion regulation with an emphasis on experiential avoidance. If parents model emotion regulation for their children, distressing life events could impact this process. The literature reviewed indicates that experiential avoidance is a mechanism involved in the etiology of psychopathology. Consequently, it was proposed that traumatic life events experienced by parents in particular impact their experiential avoidance, and as a form of experiential avoidance, parents may engage in excessive problem behaviors. This relationship, which is already problematic, becomes particularly detrimental if children's emotion regulation strategies are contingent upon the

modeling of their parent. Thus, a cycle in which individuals fail to acquire effective regulatory strategies is perpetuated, exacerbated by engagement in problem behaviors, and facilitates poor mental health outcomes. It was hypothesized that parents who report reliance on experiential avoidance and directly experiencing at least one PTE could be at risk for modeling ineffective regulatory strategies for their children. Study hypotheses were constructed on: a) the empirical findings that parent and adolescent experiential avoidance and posttraumatic stress symptoms are related (Polusny et al., 2011), b) evidence for relationships among excessive behaviors, experiential avoidance, and childhood trauma (Kingston et al., 2010), and c) empirical support for parenting stress and experiential avoidance as predictors of child behavior problems (Coyne & Thompson, 2011).

A series of hypotheses guided this study:

Hypothesis 1: The associations between parent and young adult child experiential avoidance, trauma history, posttraumatic stress symptoms, and excessive behaviors were evaluated. The following predictions were made:

H1a) There will be a positive correlation between parent experiential avoidance and parent excessive behaviors.

H1b) Young adult child experiential avoidance will positively correlate with young adult child excessive behaviors.

H1c) Parent experiential avoidance will positively correlate with young adult child experiential avoidance.

H1d) Parent excessive behaviors will positively correlate with young adult child excessive behaviors.

H1e) Parent trauma history will positively correlate with parent posttraumatic stress symptoms.

H1f) Young adult child trauma history will positively correlate with young adult child posttraumatic stress symptoms.

H1g) Parent trauma history will positively correlate with young adult child posttraumatic stress symptoms.

Hypothesis 2: An omnibus test was used in a series of regression equations to assess how well predictor variables including parent trauma history, parent experiential avoidance, young adult child trauma history, young adult child experiential avoidance, parent excessive behaviors, and parent posttraumatic stress symptoms predicted outcome variables including parent posttraumatic stress symptoms, parent excessive behaviors, young adult child posttraumatic stress symptoms, young adult child excessive behaviors, and young adult child experiential avoidance. The strength of prediction and assessment of amount of unique variance explained by predictors, controlling for other predictors, was subsequently evaluated. The following hypotheses were proposed:

H2a) Parent trauma history and parent experiential avoidance will contribute unique variance to parent posttraumatic stress symptoms. The addition of parent experiential avoidance will strengthen the predictive model of parent posttraumatic stress symptoms above parent trauma history alone.

H2b) Parent trauma history and parent experiential avoidance will contribute unique variance to parent excessive behaviors. Parent experiential avoidance will strengthen the predictive model of parent excessive behaviors above parent trauma history.

H2c) Young adult child trauma history and young adult child experiential avoidance will contribute unique variance to young adult child posttraumatic stress symptoms. Specifically, it was hypothesized that young adult child experiential avoidance would strengthen the predictive

model of young adult child posttraumatic stress symptoms above young adult child trauma history.

H2d) Young adult child trauma history and young adult child experiential avoidance will contribute unique variance to young adult child excessive behaviors. It was hypothesized that young adult child experiential avoidance would strengthen the predictive model of young adult child excessive behaviors above young adult child trauma history.

Hypothesis 3: Parent trauma history, young adult child trauma history, parent excessive behaviors, parent experiential avoidance, and parent posttraumatic stress symptoms will contribute unique variance to young adult child experiential avoidance.

H3a) It was hypothesized that parent experiential avoidance would strengthen the predictive model of young adult child experiential avoidance above parent trauma history, young adult child trauma history, parent excessive behaviors, and parent posttraumatic stress symptoms.

Hypothesis 4: Parent trauma history, young adult child trauma history, parent excessive behaviors, parent experiential avoidance, and parent posttraumatic stress symptoms will contribute unique variance to young adult child posttraumatic stress symptoms.

H4a) It was hypothesized that parent experiential avoidance would strengthen the predictive model of young adult child posttraumatic stress symptoms above parent trauma history, young adult child trauma history, parent excessive behaviors, and parent posttraumatic stress symptoms.

Hypothesis 5: Parent trauma history, young adult child trauma history, parent excessive behaviors, parent experiential avoidance, and parent posttraumatic stress symptoms will contribute unique variance to young adult child excessive behaviors.

H5a) It was hypothesized that parent experiential avoidance would strengthen the predictive model of young adult child excessive behaviors above parent trauma history, young adult child trauma history, parent excessive behaviors, and parent posttraumatic stress symptoms.

Method

Participants

Sixty dyads ($N = 120$) comprising undergraduate and high school students and their parents were recruited for the study. The sample pool was solicited through Eastern Michigan University (EMU) college classrooms and two Explore Eastern Day events held at EMU.

Procedure and Recruitment

Procedure and recruitment method one. Eastern Michigan University students enrolled in psychology courses were provided with information read from a script detailing the study (see Appendix A) from instructors regarding the opportunity to participate. This script was emailed by the student investigator to all introductory psychology course instructors. The script explained that the study proposed to examine certain difficult life events and emotional responses and behaviors that could be related to these events. It also discussed the requirement that parents or former primary caregivers of the EMU student be recruited for participation. Interested students were provided with the link to the study on EMU *SONA* Research Participation systems by course instructors. Research fliers (see Appendix B) advertising the study and containing email information for the student investigator were posted on bulletin boards in the Mark Jefferson Science Complex at EMU and varying locations on campus. Students who obtained contact information from fliers would be emailed a link to the survey by the student investigator, but no students contacted the investigator via this method.

First, potential participants viewed an informed consent document (see Appendix C) explaining the purpose of the study and the risks and benefits, time commitments, a statement that participation was voluntary and answering questions that may make one uncomfortable

would not be required, and detailing the means taken to ensure confidentiality of all data. If the participant confirmed agreement to the terms in the informed consent document by clicking the agree button, a page with the demographic questionnaire (see Appendix D) appeared. The initial item instructed participants to supply contact information for one of their parents/guardians or former primary caregivers. Parents who have an email address and internet access were contacted by the student investigator using an email or mailing recruitment script. The script explained that their participation was being requested, that participation would be confidential and voluntary, and that their young adult child would be compensated with a gift card should they complete the survey (see Appendix E). This script also contained a link at the end of the document to the online survey. If the parent elected to participate, they could follow the link to complete the survey online through *SONA* systems and Survey Monkey. Parents who did not have an email address or internet access had the option to be mailed the recruitment script, informed consent document, and demographic and survey measures via postal mail with instructions to mail the signed consent document and completed demographics and survey measures back to the faculty investigator. However, no parent participants were recruited using this method.

Upon completion of the demographic questionnaire, a battery of self-report measures were administered via the Survey Monkey website on *SONA* systems. Every individual who was enrolled as an EMU student participant accessing the *SONA* systems was eligible to receive extra credit compensation from their instructor. However, the decision to award extra credit points was ultimately determined by course instructors. In addition to extra credit, parents were informed that their student would receive a small gift card for parent completion of the survey. This reminder was displayed in the email/postal mailing script, informed consent document, at the top

of the demographic questionnaire, and on the final page of the survey with contact information for the student investigator to obtain the gift card. However, in order to receive the gift card compensation, both members of the dyad were required to complete the survey.

The confidential identification numbers were assigned to each member of the dyad such that they appropriately identified whether the participant was a parent or young adult child, but contained no identifying information. These were used to help study investigators decipher between parent and young adult child data. Parent-young adult child dyads were coded with parents' identification numbers containing an *X* and young adult child data a *Y*. As there were two methods of recruitment used, parents and young adult children recruited via the first method contained a *1* after their identification letter. Although the demographic questionnaire assessed for modality of recruitment, recording recruitment method in the confidential identification number also aided the investigator in monitoring the information during data analyses. The final component of the code number was a shared number between parents and young adult children. This shared number was determined based on the order of the young adult child's survey completion. For instance, the first research participant was assigned a number *1* and the respective parent was also assigned this number despite the order of survey completion in conjunction with other participants. Survey Monkey data were downloaded each week and stored on the secure EMU server. Code numbers were determined after each survey was downloaded and stored in an encrypted online master list also stored on the EMU secure server. These ensured names were not associated with data, protecting confidentiality of responses, while allowing the researchers to have a link between participant responses and identification numbers based on order of survey completion. If questionnaires were not completed by the parent within two weeks of receipt of the link to the survey, the student investigator followed up with an email

reminder to complete the survey or postcard. The potential for data to be duplicated was addressed as a consideration. Potential identifiers such as the participants' last two letters of their middle name (last name if they did not have a middle name) and last four digits of their cell phone number (home number, if no cell phone) and a frequency count were used to assess for duplication (Jones, 2010). The frequency count was compared to demographic data to assess for duplication. No duplicate data were observed in the present study.

Procedure and recruitment method two. Parent and young adult child recruitment for the second method took place at two fall Explore Eastern day events hosted for EMU students/potential EMU students and their parents, on Saturday October 5, 2013 and Saturday November 23, 2013 which were located in the Student Center at Eastern Michigan University. Attendance comprised approximately a thousand individuals per respective event. Potential participants were given handout information (see Appendix F) detailing the study and asking if interested in participating. Research assistants recruited potential participants with the participant recruitment script (see Appendix G). Interested dyads completed the survey in the reserved computer laboratory located in the Student Center with the help of trained research assistants.

Parents and young adult children who indicated an interest were assigned a confidential identification number. This identification number was similar to that mentioned above, but contain the number 2 after *X* or *Y*, indicating they were recruited via Explore Eastern day. The student investigator or research assistant delegating confidential identification numbers gave these to participants in the form of handouts containing the identification number. They entered this identification number into the question box requesting the investigator provided confidential identification number in correspondence with an item at the start of the survey. Both parents and young adult children then viewed the informed consent document and indicated whether or not

they agreed to participate. In the event that a young adult child was 17 years of age, that person filled out an assent form (see Appendix H) which was completed online using the Survey Monkey website. If participants provided consent (or assent), a second version of the demographic questionnaire (see Appendix I) excluding the item inquiring for parent contact information appeared on the screen. Participants then completed the self-report measures that are explained in greater detail in the measures section of this document. After both members of the dyad completed the survey, they were thanked for their participation, debriefed to the nature of the study (see Appendix J), and presented with a gift card. In the event that individuals could not participate at that moment, but would be available to participate at a later date, packets of information including the study fliers, investigator contact information, and a link to the survey were provided.

Measures

A demographic questionnaire assessing participant characteristics including gender, ethnicity, age, relationship status, educational status, annual household income, and whether the participant was the parent or young adult child were administered online. As mentioned in the procedures, items on the demographic questionnaire were modified to assess whether participants completed the survey online at home or in person at the Explore Eastern day. This questionnaire can be found in appendix D of this document, as referred to above.

Multidimensional experiential avoidance questionnaire (MEAQ; Gámez, Chmielewski, Kotov, Ruggero, & Watson, 2011; see Appendix K). The MEAQ is a 62-item self-report measure that was developed to address a wider range of experiential avoidance than measured in the Acceptance and Action Questionnaire (AAQ) and AAQ-II. It was also developed to address issues with internal consistency and poor discriminant validity that have

often been evidenced with other measures of experiential avoidance. The MEAQ contains questions pertaining to six dimensions of experiential avoidance: behavioral avoidance, distress aversion, procrastination, distraction and suppression, repression and denial, and distress endurance. Items are rated on a Likert-type scale, ranging from 1 = *strongly disagree* to 6 = *strongly agree*, and higher scores are indicative of greater experiential avoidance. The MEAQ has demonstrated good internal consistency and excellent convergent validity with avoidance measures and related constructs including thought suppression, stress avoidance, social avoidance, and alexithymia. It also has excellent discriminative validity and greater assessment of unique content through the six subscales. This assessment instrument served as one of the measures of experiential avoidance among the study sample.

Acceptance and action questionnaire-II (AAQ-II; Bond, Hayes, Baer, Carpenter, Guenole, Orcutt, Waltz, & Zettle, 2011; see Appendix L). The AAQ-II is a 7-item self-report measure of experiential avoidance, rated on a seven-point Likert-type scale (ranging from 1 = *never true* to 7 = *always true*) with higher scores suggesting increased experiential avoidance and lower scores reflecting greater psychological flexibility. Specifically, it was used to measure the unwillingness to sustain contact with distressing or negatively evaluated private events and attempts to alter their form, frequency, and contexts occasioning them. Both parents and young adult children were administered this measure. The AAQ-II has demonstrated good internal consistency (alpha coefficient mean of .84). It also has good test-retest reliability of .81 and .79 for twelve and three months, respectively. A reliability coefficient between measures of experiential avoidance (MEAQ and AAQ-II) was also calculated. Discrepancies between measures of experiential avoidance (MEAQ and AAQ-II) were assessed.

Composite measure of problem behaviors (CMPB; Kingston, Clarke, Ritchie, and Remington, 2011; see Appendix M). The CMPB is a 46-item measure of ten different problems behaviors including: nicotine use, deliberate self-harm, excessive internet/computer game use, drug use, excessive exercise, excessive alcohol use, binge eating, sexual promiscuity, aggression, and restrictive eating. Participants endorse the items on a six-point scale (ranging from 1 = *very unlike me* to 6 = *very like me*). Confirmatory factor analysis delineated a common higher order factor explaining covariation between the subscales, important for our hypothesis that topographically dissimilar behaviors may be explained by a common pathway that could serve an avoidance function. This measure was developed and validated based on the common finding that problem behaviors co-occur. The subscales of the CMPB have good construct validity with other psychometrically validated measures including the Alcohol Use Disorders Identification Test ($r = .76$), the Sociosexual Orientation Inventory ($r = .56$), the Three Factor Eating Questionnaire ($r = .50$), and the Deliberate Self-Harm Inventory ($r = .71$; see Kingston et al., 2011). The CMPB also has good internal consistency ($\alpha = .73-.91$) and test-retest reliability (95% CI). Reliability estimates were also stable across time periods of: two weeks ($r = .73-.98$), two-four months ($r = .69-.91$), and eight-fourteen months ($r = .65-.91$). The CMPB was used to assess for potential relationships between parent and young adult child excessive behaviors as well as their relationship to other study variables including experiential avoidance and posttraumatic stress symptoms.

Life events checklist (LEC; Gray, Litz, Hsu, & Lombardo, 2004; see Appendix N). The LEC is a 17-item checklist of trauma exposure established at the National Center for PTSD, used to assess PTEs and usually administered as a screening tool with the CAPS for DSM-IV (Weathers, Keane, & Davidson, 2001). The LEC inquires about various PTEs such as natural

disasters, assault with a weapon, sexual assault, transportation accidents, and any other type of stressful life experience. It also allows participants to endorse the form of exposure (*happened, witnessed, learned about it, not sure, doesn't apply*) for each item. Individuals may also endorse exposure to multiple PTEs. The LEQ has adequate test-retest reliability over a seven-day period ($M = .61$) and good convergent validity with the Traumatic Life Events Questionnaire (TLEQ) with a mean of $.70$. The LEC was administered to both parents and young adult children to assess type and method of trauma exposure.

Posttraumatic stress disorder checklist-civilian version (PCL-C; Weathers, Litz, Herman, Huska, & Keane, 1993, see Appendix O). The PCL-C is a 17-item self-report measure assessing for the presence of criterion B, C, and D DSM-IV PTSD symptoms. It assesses levels of distress related to each symptom within the past thirty days. Items are rated on a scale 1 = *not at all* to 5 = *extremely*. Although there are actually three versions of this measure, the PCL-Military version, PCL-Specific (designed to assess PTSD symptoms in regards to a specific stressor), and the PCL-C, there are only slight differences in each and the psychometric properties for each measure since they are highly similar. This specific version of the measure is geared toward more general populations of individuals exposed to trauma and does not assess for symptoms specific to any traumatic event, but rather broad exposure. The civilian version was used, as recruitment consisted of a non-military population. A total severity score was calculated to determine symptom severity as well as a potential diagnosis of the presence of DSM-IV PTSD.

Test-retest reliability for the PCL is reported at $.92$ ($p < .001$) among immediate retesters, $.88$ ($p < .001$) for participants within one-week retest intervals and $.68$ ($p < .001$) at two-week retest periods (Ruggiero, Del Ben, Scotti, & Rabalais, 2003). Cronbach's alpha coefficients

calculated for the measure have demonstrated high internal consistency for the PCL-C total, re-experiencing, avoidance, and hyperarousal scales (.94, .85, .85, .87, respectively). Convergent validity was found between the PCL-C and the Impact of Events Scale and the Mississippi Scale for PTSD-Civilian (MS-C) ($r = .77$; $r = .82$, respectively). The PCL-C has also shown discriminant validity. Specifically, the PCL-C and MS-C correlation coefficients were significantly greater than correlations between the PCL-C and the Symptom Checklist 90-Revised, $t(392) = 5.42, p < .001$; as well as the Center for Epidemiologic Studies-Depressed Mood Scale, $t(392) = 6.95, p < .001$. The PCL-C was administered to assess posttraumatic stress symptom severity in the present study. It has been recommended that a cutoff score of 44 and above for a PTSD diagnosis that carries good sensitivity and specificity (.78-.82 and .83 to .86, respectively) be used (Blanchard, Jones, Alexander, Buckley, & Forneris, 1996). The PCL-C was administered to determine participant posttraumatic stress symptom severity and thus was coded as a continuous variable.

Design

This study utilized a cross-sectional design to explore the relationships between the variables of interest. Specifically, the impact of experiential avoidance on experiences of PTEs in parents as historical variables that may increase posttraumatic stress symptoms was examined. Dyadic associations between parent experiential avoidance and young adult child experiential avoidance were subsequently explored. The relationship between experiential avoidance and engagement in excessive, problematic behaviors among the dyads was examined.

This study was submitted to the Eastern Michigan University, College of Arts and Sciences, Humans Subjects Institutional Review Board (HSIRB) and received implementation approval from 9/30/2013-9/29/2014. A copy of the approval letter can be referenced in Appendix P.

Results

Statistical Packaging for the Social Sciences (SPSS) Version 21 was used to conduct statistical analyses. Data were entered into a computer database using SPSS software and saved and stored on a password protected computer in a research laboratory at EMU. Research participants consisted of sixty parent and young adult child dyads ($N = 120$) recruited predominately from two campus tour events at Eastern Michigan University ($n = 48$ dyads), with the rest of the sample recruited from Eastern Michigan University psychology courses ($n = 12$ dyads). The mean age reported by young adult children was 18 ($SD = 3$), with a range of 15-31. Parent participants reported a mean age of 46 ($SD = 7.8$), ranging in age from 32-70. The majority of parent and young adult child participants were female (75% and 73%, respectively). In ethnicity, the sample demonstrated considerable diversity, with 32% and 33% of parents and young adult children respectively identifying as a variety of ethnicity other than European-American. Demographic data are on display in Table 1. Ninety-eight percent of parents and 83% of young adult children reported exposure to at least one PTE. The sample pool varied in terms of PTEs endorsed and the events they endorsed as most distressing. Results are presented in Table 2. The most common PTE reported by parents was a transportation accident, while young adult children rated “other stressful life event or experience” as their most common PTE. Parents and young adult children most prevalently rated the “sudden, unexpected death of someone close to you” as their most distressing PTE.

Preliminary Data Analyses

Dyadic analyses and restructuring the dataset. The *Actor Partner Interdependence Model* (APIM) (Kenny, Kashy, & Cook, 2006), an assumption of non-independence in dyadic data analyses was not violated because no outside independent variable was hypothesized to directly impact both members of the dyad (e.g., impact of divorce on former husband and wife

quality of life). Information regarding whether PTEs were experienced mutually was not obtained, and therefore was not evaluated as a contributing factor. Data were restructured in a way that parent and young adult child variables were independent of one another, dichotomizing parent and young adult child levels of trauma history, experiential avoidance, posttraumatic stress symptoms, and excessive behaviors. As such, statistical approaches that correct for the APIM (pooled regression, multilevel modeling, and structural equation modeling) were not employed (Kenny, Kashy, & Cook, 2006).

Normality, linearity, and homoscedasticity. The distributions for all variables of interest were evaluated. Skewness and kurtosis, measures of distribution normality, were first assessed. According to Mertler and Vannatta (2005), skewness and kurtosis values that have coefficient values between -1 and +1 are considered normal. Although these authors recommend skewness and kurtosis values should fall as close to zero as possible, a distribution may still be considered normal with values that range within the above mentioned -1 to +1 range. The first measure of experiential avoidance, the MEAQ, restructured to include young adult child responses only, was found to have a skewness value of $-.450$ ($SE = .311$) and a kurtosis value of $.300$ ($SE = .613$). Parent MEAQ data showed a skewness value of $.080$ ($SE = .311$) and kurtosis of $-.029$ ($SE = .613$). Therefore, no transformations were computed. Histograms computed for young adult child and parent MEAQ scores appeared relatively normal. Normal Q-Q Plots also supported the finding that data fell in a linear pattern. According to the respective stem and leaf plot, young child scores on the MEAQ contained one outlier, but the split between this score and the rest of the distribution did not appear severe enough to warrant deletion of this case.

Young adult child and parent data were next screened on responses to the second measure of experiential avoidance, the AAQ-II. Skewness was equivalent to $.132$ ($SE = .311$) and kurtosis

was $-.569$ ($SE = .613$) for young adult children, while skewness values were 1.005 ($SE = .311$) and kurtosis was $.424$ ($SE = .613$) for parent participants. No transformations were computed for the AAQ-II. The histogram appeared relatively normally distributed for young adult children, while the histogram for parents showed a slight positive skew. An evaluation of the Normal Q-Q Plots showed the young adult children's scores on the AAQ-II mostly fell on a straight line, and parents appeared to taper slightly from the line. Two outliers were observed on the parent AAQ-II variable, but they did not appear extreme enough to delete as there were no notable differences in results computed including and excluding these outliers.

Skewness and kurtosis values of the LEC, the measure of cumulative PTEs that participants endorsed had "*happened*" to him or her, were next evaluated. For young adult children in the sample pool, skewness fell at $.761$ ($SE = .311$) and kurtosis was $.192$ ($SE = .613$). Parent LEC skewness was $.714$ ($SE = .311$) and kurtosis was $.043$ ($SE = .613$). The histogram for young adult children's responses to the LEC appeared slightly positively skewed, while parent responses seemed more normally distributed. Participants' responses as graphed by the Normal Q-Q Plot fell on the line, in general. One outlier was recorded for young adult children, but was included in the remaining analyses because it did not differ exceedingly. No transformations were computed for the LEC variable.

Young adult children evidenced a skewness value of $.878$ ($SE = .311$) and a kurtosis value of 1.264 ($SE = .613$) on the PCL-C, the measure of PTSD symptom severity. Parents displayed a skewness value of 1.896 ($SE = .311$) with kurtosis falling at 5.023 ($SE = .613$). The histogram for young adult children showed a moderate positive skew while the histogram for parents displayed a severe positive skew. Young adult children's scores, in general, fell on a straight line upon consultation of the Normal Q-Q Plot. Parent's PCL-C scores seemed to trend

around the line in the Normal Q-Q Plot, but evidenced some dispersion for several participants' cases. One outlier was observed for young adult children on the PCL-C, while three outliers were observed for parents. To correct for positive skewness of the distribution, a logarithm + 10 was computed. Corrected skewness and kurtosis values for young adult children were .078 ($SE = .311$), $-.776$ ($SE = .613$), $.722$ ($SE = .311$), and $.279$ ($SE = .613$) respectively. Visually, the histograms appeared more normally distributed and the Normal Q-Q Plot data trended around the straight line in the plot for both. One case for parents revealed an outlier, but this outlier was not extreme enough to exclude from analyses.

Next, a composite score calculated using young adult children and parent responses to the CMPB, the measure of engagement in ten different problem behaviors, was assessed for violations of assumptions. Skewness for young adult children fell at $.368$ ($SE = .311$) and kurtosis at $-.788$ ($SE = .613$). Parent CMPB skewness was $.674$ ($SE = .311$) and kurtosis was $.409$ ($SE = .613$). Young adult child data did not demonstrate much skewness per the histogram, but parent CMPB data appeared to be slightly positively skewed. There was some dispersion of participants' scores on the Normal Q-Q Plots for both members of the dyad. No outliers were recorded for either young adult children or parents on the CMPB. Data on the total CMPB measure were not transformed because the skewness values did not exceed -1 or $+1$. Although slight violation of linearity was evidenced in reference to the Normal Q-Q Plots discussed above, analyses were not jeopardized enough to warrant transformations for this reason (Mertler & Vannatta, 2005). Means, standard deviations, and internal consistency Cronbach's alpha coefficients of study variables determined by dyadic membership are presented in Table 3.

Bivariate Correlations

Pearson's product moment correlations were computed between study variables separately for young adult children and parents. Correlations were also assessed between dyadic members. The results of these correlations are contained in three separate correlation matrices (see Tables 4, 5, and 6).

Parent measure relationships. In support of hypothesis (1a), parent AAQ-II scores and parent excessive behaviors evidenced a strong, positive association ($r = .59, p < .01$), and parent MEAQ scores and parent excessive behaviors demonstrated a strong relationship ($r = .38, p < .01$). Parent nicotine use was moderately associated with parent AAQ-II scores ($r = .37, p < .01$) and with parent MEAQ scores ($r = .35, p < .01$). Deliberate self-harm in parents was moderately correlated with parent AAQ-II scores ($r = .44, p < .01$) and with parent MEAQ responses ($r = .32, p < .05$). Internet overuse, as reported by parents, demonstrated a significant association with parent AAQ-II ($r = .44, p < .01$), and a moderate association with parent MEAQ scores ($r = .30, p < .05$). Drug use endorsed by parents also moderately linked with their AAQ-II scores ($r = .36, p < .01$) and MEAQ scores ($r = .41, p < .01$). Excessive exercise in parents; however, was not positively associated with their AAQ-II or MEAQ reports. Alcohol use in parents similarly displayed a moderate positive correlation with the AAQ-II ($r = .33, p < .01$), but interestingly was not significant when assessed using the MEAQ. Binge eating was also not associated with the AAQ-II or MEAQ among parents, although it appeared to be approaching significance with the AAQ-II. Sexual promiscuity evidenced no significant relationship with either measure of experiential avoidance in parents. However, aggression was moderately associated with both the AAQ-II ($r = .48, p < .01$) and the MEAQ ($r = .36, p < .01$). Restrictive eating showed a moderate

relationship with the AAQ-II ($r = .41, p < .01$), while it showed a small correlation with the MEAQ ($r = .29, p < .05$).

Young adult child measure relationships. A test of hypothesis (1b) showed that young adult child experiential avoidance moderately correlated with young adult child reports of overall engagement in excessive behaviors for the AAQ-II ($r = .46, p < .01$) but there was no significant relationship with the MEAQ. Thus, hypothesis (1b) seems supported per the AAQ-II, but not in terms of the MEAQ. Individual subscales of the CMPB were also evaluated. Young adult child AAQ-II scores were moderately associated with deliberate self-harm ($r = .49, p < .01$) and alcohol use ($r = .33, p < .01$), and showed a small association with aggression ($r = .26, p < .05$), and restrictive eating ($r = .29, p < .05$). Their MEAQ scores were moderately negatively associated with excessive exercise ($r = -.37, p < .01$), and moderately positively associated with deliberate-self harm ($r = .33, p < .01$).

Dyadic relationships. Regarding hypothesis (1c), parent AAQ-II and young adult child AAQ-II scores were positively correlated ($r = .27, p < .05$), although a smaller correlation. However, parent MEAQ and young adult child MEAQ scores were not significantly associated. As such, hypothesis (1c) received partial support, provided measure differences. Hypothesis (1d) was supported as overall parent excessive behaviors associated positively with young adult child engagement in excessive behaviors ($r = .26, p < .05$). Regarding the CMPB's subscales, parent and young adult child nicotine use, drug use, excessive exercise, alcohol use, binge eating, sexual promiscuity, and restrictive eating were not associated. Deliberate self-harm ($r = .31, p < .05$), internet overuse ($r = .29, p < .05$), and aggression ($r = .31, p < .05$) were associated between dyadic members, with deliberate self-harm and aggression displaying moderate correlations, and internet overuse displaying a smaller correlation effect.

Trauma history and posttraumatic stress symptoms relationships. Regarding hypothesis (1e), parent trauma history as measured by the LEC, was not significantly associated with parent posttraumatic stress symptoms assessed with the PCL-C. Hypothesis (1f) also did not show a significant relationship between young adult child trauma history and posttraumatic stress symptoms. Hypotheses (1e), (1f), and (1g) were not supported in that parent trauma history as measured by the LEC was not significantly associated with parent posttraumatic stress symptoms assessed with the PCL-C, young adult child trauma history and posttraumatic stress symptoms were not significantly related, and parent trauma history was not significantly associated with young adult child posttraumatic stress symptoms. Parent trauma history and young adult child trauma history were significantly moderately associated ($r = .30, p < .05$) and parent posttraumatic stress symptoms were significantly associated with young adult child posttraumatic stress symptoms ($r = .26, p < .05$), reporting a smaller correlation effect.

Hierarchical Multiple Linear Regression Analyses

Hierarchical multiple linear regression analyses were conducted to elucidate which predictor variables among parent experiential avoidance and PTEs most strongly predicted parent posttraumatic stress symptoms and parent excessive behaviors. Parallel regression models were also calculated for young adult children. Finally, regression analyses with parent experiential avoidance, PTEs, posttraumatic stress symptoms, and excessive behaviors as predictors of young adult child experiential avoidance, posttraumatic stress symptoms, and excessive behaviors were conducted. Although parent MEAQ and AAQ-II scores were strongly correlated ($r = .60, p < .01$), these associations and relevant others in the regression models did not reach the .80 criterion for multicollinearity. Thus, it was not observed to be an issue in any of the regression analyses.

Regression testing hypothesis (2a). The first regression equation was employed to determine the amount of variance parent trauma history and parent experiential avoidance contributed to parent posttraumatic stress symptoms in this sample. Regarding hypothesis (2a), parent trauma history was entered into the model first as it was theorized to be a more distal predictor. Parent experiential avoidance as assessed separately by the AAQ-II and MEAQ was entered in the subsequent block. Parent trauma history explained 3% of the variance in parent posttraumatic stress symptoms, $R^2 = .030$, $F(1, 58) = 2.247$, $p = .139$. As such, it did not make a significant unique contribution to parent posttraumatic stress symptoms. Parent experiential avoidance as indicated by AAQ-II and MEAQ scores explained 43.4% of the variance in parent posttraumatic stress symptoms. Parent experiential avoidance contributed an additional 42.6% of the variance to parent posttraumatic stress symptoms, $R^2 \Delta = .426$, $F(2, 56) = 22.193$, $p = .001$ beyond parent trauma history. Parent AAQ-II scores made a unique contribution to the prediction of parent posttraumatic stress symptoms ($\beta = .572$, $t = 4.660$, $p < .001$); however, parent MEAQ scores did not. Partial support was thus gathered to support this hypothesis regarding the AAQ-II, but not the MEAQ. Findings are summarized in Table 7.

As a result, a subsequent regression equation in which factors of the MEAQ (behavioral avoidance, distress aversion, procrastination, distraction and suppression, and repression and denial) were included in the model to assess potential incremental contributions of different forms of avoidance that may not be represented in the composite MEAQ scores. Parent AAQ-II symptoms remained the only significant predictor in this model as well and thus subsequent related analyses were not pursued.

Hypothesis (2b). Hypothesis (2b) was tested to assess the contributions of parent trauma history and parent experiential avoidance to parent excessive behaviors. Parent trauma history

was entered in block one, while parent experiential avoidance (AAQ-II and MEAQ) were entered in block two. Parent trauma history explained 4% of the variance in parent excessive behaviors, $R^2 = .049$, $F(1, 58) = 3.019$, $p = .088$. Parent experiential avoidance in block two contributed 39% of the variance in parent excessive behaviors and an additional 34% of the variance beyond parent trauma history, $R^2 \Delta = .344$, $F(2, 56) = 15.866$, $p = .001$. Parent AAQ-II scores were shown to be the strongest, and only statistically significant predictor of parent excessive behaviors ($\beta = .560$, $t = 4.29$, $p < .001$). Findings demonstrate partial support of hypothesis (2b). These findings are displayed in Table 8.

Hypothesis (2c). Hypothesis (2c) was then evaluated. Young adult child trauma history was entered in the initial block, while young adult child experiential avoidance scores were entered in block two. Young adult child trauma history explained 3% of the variance in posttraumatic stress symptoms, $R^2 = .03$, $F(1, 58) = 1.784$, $p = .187$. Experiential avoidance accounted for 37% of the variance in posttraumatic stress symptoms, and contributed 34% additive variance beyond trauma history, $R^2 \Delta = .340$, $F(2, 56) = 15.120$, $p = .001$. In the total model, experiential avoidance as assessed by the AAQ-II demonstrated the highest, and only statistically significant beta value ($\beta = .618$, $t = 5.278$, $p < .001$). Findings overall suggest that the experiential avoidance construct measured using the AAQ-II was the strongest predictor of posttraumatic stress symptoms. These results provide partial support for the initial hypothesis as experiential avoidance was indeed the strongest predictor, but only as assessed by the AAQ-II. A summary of this regression analysis is displayed in Table 9.

Hypothesis (2d). In computing the results to inform hypothesis (2d), young adult child trauma history was entered in block one and young adult child experiential avoidance scores, AAQ-II and MEAQ, were input in block two to assess predictive power for young adult child

excessive behaviors. Young adult child trauma history did not predict young adult child excessive behaviors, $R^2 = .004$, $F(1, 58) = .219$, $p = .642$. At block two, experiential avoidance accounted for 26% of the variance in young adult child excessive behaviors, and accounted for an additional 25.7% of the variance, $R^2 \Delta = .257$, $F(2, 56) = 9.734$, $p = .001$. Only AAQ-II scores showed a unique contribution to young adult child excessive behaviors ($\beta = .559$, $t = 4.411$, $p < .001$). Partial support was thus provided for the hypothesis that young adult child experiential avoidance most strongly predicts engagement in topographically dissimilar problem behaviors. Discrepancies were again observed in measurement of experiential avoidance as a unique contributor to engagement in excessive behaviors. Model coefficients are on display in Table 10.

Hypothesis (3) and (3a). Hierarchical multiple linear regression analyses were also used to assess parent trauma history, experiential avoidance, posttraumatic stress symptoms, and excessive behaviors as predictors of young adult child experiential avoidance, posttraumatic stress symptoms, and excessive behaviors. It was hypothesized that parent experiential avoidance would be the strongest predictor of young adult child experiential avoidance.

To test hypothesis (3a), a hierarchical multiple regression model was computed with young adult child experiential avoidance (AAQ-II) as the outcome variable. The predictors in the model were parent and young adult child trauma history in block one, parent posttraumatic stress symptoms in block two, parent excessive behaviors in block three, and parent experiential avoidance (both AAQ-II and MEAQ) in block four. This model did not account for a statistically significant amount of the variance in young adult child experiential avoidance. Hence, the unique contributions of the predictors were not assessed. A separate regression equation was conducted using these same variables predicting young adult child MEAQ scores. The model was non-

significant as well. A third regression equation was estimated with parent trauma history at block one and parent AAQ-II scores in block two, with young adult child AAQ-II scores serving as the criterion. In this model, parent trauma history explained 2% of the variance, $R^2 = .024$, $F(1, 58) = 1.407$, $p = .240$ in block one, while parent experiential avoidance contributed 6% of the variance beyond parent trauma history, $R^2 \Delta = .071$, $F(1, 57) = 2.981$, $p = .039$. In this final model, parent experiential avoidance did account for unique variance in young adult child experiential avoidance as measured by the AAQ-II ($\beta = .267$, $t = 2.115$, $p < .05$). Although parent experiential avoidance was found to be a unique contributor in the subsequent regression, the hypothesis that it would strengthen the predictive model above parent and young adult child trauma history, parent posttraumatic stress symptoms, and parent excessive behaviors was not supported. Results are presented in Table 11.

Hypothesis (4) and (4a). Hypothesis (4) and (4a) regarding young adult child posttraumatic stress symptoms was tested through entering parent trauma history and young adult child trauma history in the first block of a hierarchical multiple linear regression. Parent posttraumatic stress symptoms were then entered in the subsequent block. Parent excessive behaviors were added in block three, while parent experiential avoidance, was entered in the fourth block. These variables were estimated as predictors of young adult child posttraumatic stress symptoms. At block one, parent and young adult child trauma history explained 6% of the variance in young adult child posttraumatic stress symptoms, $R^2 = .064$, $F(2, 57) = 1.953$, $p = .151$. In block two, parent posttraumatic stress symptoms contributed 14.7% of the variance and an additional 8.3% beyond trauma history in block one, $R^2 \Delta = .083$, $F(1, 56) = 5.426$, $p = .023$. Parent excessive behaviors explained no additional variance to the model in block three, $R^2 \Delta = .000$, $F(1, 55) = .028$, $p = .867$. In block four, parent experiential avoidance contributed 15.7%

of the variance to the prediction of young adult child posttraumatic stress symptoms, and thus did not make a significant contribution beyond that of the other predictor variables. In the final model, parent posttraumatic stress symptoms proved to be the best predictors of young adult child posttraumatic stress symptoms, making a unique contribution ($\beta = .300, t = 2.329, p < .05$). These coefficients are displayed in Table 12.

Hypothesis (5) and (5a). Next, hypothesis (5a) was evaluated. In block one, parent and young adult child trauma history were entered. Parent posttraumatic stress symptoms were entered in block two. Parent excessive behaviors were then added to the model in block three. Finally, parent experiential avoidance was added in block four. These predictor variables were added to the model to assess prediction and contribution of unique variance to young adult child excessive behaviors as an outcome variable. Hypothesis (5a) was not supported as the regression model did not account for a significant amount of the variance in young adult child excessive behaviors.

Given the bivariate associations found between parent and young adult child aggression, deliberate self-harm, and internet overuse, three separate regression equations were estimated with the aforementioned young adult child excessive behaviors entered as respective outcome variables. Parent subscales of the CMPB were added to block three. Regarding young adult child aggression, parent and young adult child trauma history at block one accounted for only 5% of the variance in young adult child aggression, $R^2 = .050, F(2, 57) = 1.485, p = .235$. In block two, parent posttraumatic stress symptoms explained 7% of the variance, adding only 2% beyond block two, $R^2 \Delta = .020, F(1, 56) = 1.208, p = .277$. Thirty-nine percent of the variance in block three was explained by the addition of parent excessive behavior individual subscales, predicting 31.7% more of the variance in young adult child aggression, $R^2 \Delta = .386, F(11, 45) = 2.110, p =$

.039. At block four, it was found that 41.4% of the variance in young adult child aggression was explained by the addition of parent experiential avoidance. Experiential avoidance only contributed 2% further to the model, $R^2 \Delta = .021$, $F(2, 43) = .770$, $p = .374$.

Unique contributions were made in block three by young adult child trauma history ($\beta = .294$, $t = 1.995$, $p < .05$), parent nicotine use ($\beta = 1.909$, $t = 2.320$, $p < .05$), parent deliberate self-harm ($\beta = .798$, $t = 2.724$, $p < .01$), parent drug use ($\beta = 1.029$, $t = 2.200$, $p < .05$), parent alcohol use ($\beta = 1.686$, $t = 2.868$, $p < .01$), parent internet overuse ($\beta = 1.579$, $t = 2.538$, $p < .05$), parent excessive exercise ($\beta = 1.556$, $t = 2.355$, $p < .01$), parent binge eating ($\beta = 1.035$, $t = 1.986$, $p < .05$), parent sexual promiscuity ($\beta = 1.248$, $t = 2.374$, $p < .05$), and parent aggression ($\beta = 1.335$, $t = 2.760$, $p < .01$). With young adult child deliberate self-harm as the outcome, the same regression equation was estimated, but the total model was not statistically significant in any of the blocks. Significance was also not observed when young adult child internet overuse was regressed on the abovementioned predictor variables. Results may be found in Table 13.

Discussion

The aims of this study were to more completely determine specific vulnerability factors for experiential avoidance, posttraumatic stress symptoms, and engagement in overt, problematic behaviors post-trauma. Excessive behaviors were conceptualized based on Kingston, Clark, and Remington's (2010) findings that such behavior may serve an experiential avoidance or avoidant coping function. Study design was informed by an intergenerational, dyadic perspective in which parental avoidance strategies, traumatic life experiences, and distress in the form of posttraumatic stress symptoms were analyzed for their effects on their young adult children. Relative contributions of individual trauma history and coping methods on important outcomes including posttraumatic stress symptoms, experiential avoidance and unhealthy behaviors were addressed.

Participants were predominately Caucasian and the majority of both parents and young adult children described themselves as female. Almost every parent and young adult child participant reported exposure to at least one PTE. Contrary to hypotheses, trauma exposure was not associated with posttraumatic stress symptoms within and between dyadic members. The LEC total score was generated based on events that participants endorsed had "happened" to him or her. Although this is standard for scoring the measure, the findings may look different accounting for events described as "witnessed" or "learned about." It is also possible that symptoms participants endorsed experiencing more severely on the PCL-C (e.g., difficulties concentrating or falling asleep) were not trauma related. No clinical interviews were administered and therefore explicit speculations cannot be formed. The absence of a correlation between trauma history and posttraumatic stress symptoms may also be due to statistical power

or sample characteristics. Participants recruited from a clinical sample might show a stronger and more significant association between trauma history and posttraumatic stress symptoms.

Parent and young adult child trauma history were correlated. The influence of shared events could be one potential explanatory variable. However, this claim cannot be substantiated as there was no item to assess mutuality of events between parent and young adult child. The number of individuals reporting exposure to “sudden violent death,” and “serious injury, harm, or death you caused to someone else” corresponded between dyadic members ($n = 4$), but other events appeared more divergent. Event endorsed as most distressing (“sudden unexpected death of someone close to you”) was common among parents and young adults.

Parent and young adult child posttraumatic stress symptoms were associated. This finding seems consistent with the majority of parent-child posttraumatic stress/PTSD literature among individuals who have been exposed to a variety of traumatic events (Leen-Feldner, Feldner, Knapp, Bunaciu, Blumenthal, & Amstadter, 2013). Meaningful differences also appeared to emerge regarding use of experiential avoidance and its links with other variables in parents and young adult children, albeit not entirely in expected directions. Further examination of the correlates of posttraumatic stress symptoms revealed that young adult child posttraumatic stress symptoms were strongly related to their AAQ-II scores, but not with MEAQ scores. AAQ-II scores have been found to be robust predictors of posttraumatic stress symptoms among different samples including convenience samples, clinical samples, and military veterans (e.g., Marx & Sloan, 2005; Meyer et al., 2013; Shenk et al., 2012). However, the MEAQ seems to have been examined within the context of PTSD in only one study (Dvorak, Arens, Kuvaas, Williams, & Kilwein, 2013). In the aforementioned study, pathways to alcohol use and alcohol-use consequences appeared to differ between individuals with high and low levels of PTSD

symptoms and the distress aversion subscale of the MEAQ was linked with alcohol-related consequences through motives (social, coping, enhancement, conformity) and use. The present study is unique in its use of both the MEAQ and AAQ-II as measures of experiential avoidance.

Young adult child reports of posttraumatic stress symptoms were moderately correlated with the procrastination subscale of the MEAQ and strongly correlated with the repression and denial subscale of the MEAQ. The nicotine use subscale of the CMPB was also strongly associated with posttraumatic stress symptoms, as were deliberate self-harm, and aggression, and was moderately associated with alcohol and drug use. Correspondingly, parent posttraumatic stress symptoms were also strongly associated with their MEAQ scores and the behavioral avoidance, distress aversion, procrastination, and repression and denial subscales of the MEAQ. Parent posttraumatic stress symptoms were also strongly associated with their AAQ-II scores as well as nicotine use and sexual promiscuity on the CMPB.

One potential interpretation of these findings could be that posttraumatic stress responses are modeled by parents. Symptom trajectory may also be explained by independent responses to parallel, stressful events. The strength of the experiential avoidance and posttraumatic stress symptoms relationships as measured by the AAQ-II, but non-universal findings in parents and young adults for the MEAQ are more complex. It is conceivable that the association between young adult child AAQ-II scores and posttraumatic stress symptoms could be more fully illuminated by measure item overlap. For example, the items “my painful experiences and memories make it difficult for me to live a life I would value” and, “my painful memories prevent me from living a fulfilling life” seem to overlap with the construct of posttraumatic stress. Conceptually, these items could tap symptoms related to reliving or intrusive memories. The MEAQ includes comparable items (e.g., “when upsetting memories come up, I try to think

of other things”), but the multifactorial nature of the measure might be responsible for the divergent findings. While the AAQ-II appears to be measuring distress about emotion, the factors of the MEAQ that emerged as important in these analyses have to do with shutting down emotion. It is unclear why parent MEAQ scores related strongly with their posttraumatic stress symptoms, while young adult children’s MEAQ scores did not. Experiential avoidance and posttraumatic stress symptoms may become more elevated in parents due to relatively greater environmental demands (e.g., supporting a family). Length of time relying on experiential avoidance may also be critical. Parents may simply acquire a stronger history of reinforcement for engaging in experiential avoidance and thus hold significantly different repertoires than their children. Exposure to increasingly difficult or stressful life events later as time evolves may interact with already shaped or evolving experiential avoidance levels

Strong associations were also discovered between AAQ-II scores and MEAQ total scores in young adult children. The procrastination and repression and denial subscales were strongly associated with young adult child AAQ-II scores, while their AAQ-II scores were moderately associated with the distress aversion subscale and moderately negatively associated with distress endurance. The absence of a significant relationship between the AAQ-II and behavioral avoidance subscale makes sense as the items appear to reflect greater difficulties with distressing private events, rather than behavioral efforts to gain distance from these events.

In evaluating relations between young adult child experiential avoidance and excessive behaviors, a strong relationship was elucidated between AAQ-II scores and excessive behaviors. However, no significant association emerged between MEAQ scores and excessive behaviors. There was also no relation between trauma exposure and engagement in excessive behaviors. Mediational data support experiential avoidance as a mechanism by which childhood trauma

exposure influenced outcomes including engagement in problem behaviors and psychological distress in adulthood in several studies (Kingston, Clarke, & Remington, 2010; Polusny et al., 2004). Based on these findings, stressful life events experienced in childhood may interfere with the development of coping strategies that lead to effective outcomes, or learned coping may render children unprepared for any traumatic event that occurs. This trajectory is likely complicated by parental experiential avoidance.

In exploring specific CMPB subscales, deliberate self-harm and alcohol use displayed moderate correlations with AAQ-II scores in young adult children, while small associations were also found between AAQ-II scores and young adult child aggression and restrictive eating. Young adult child MEAQ scores were moderately associated with deliberate self-harm and moderately negative associated with excessive exercise, whereas the other CMPB subscales were not significantly associated with MEAQ scores. These findings represent measurement discrepancies in links to excessive behaviors for young adult children. Parent AAQ-II scores were strongly associated with their MEAQ scores and the behavioral avoidance, distress aversion, procrastination, and repression and denial subscales of the MEAQ. Parent AAQ-II scores were also strongly associated with the total CMPB score and moderately associated with nicotine use, drug use, and aggression, and moderately associated with deliberate self-harm, internet overuse, and restrictive eating. Most subscales were consistent in their significant links with both measures of experiential avoidance for parents, which is a contradictory finding from those observed for young adult children. Furthermore, young adult child and parent AAQ-II scores were associated with one another, while there was no significant relationship between their MEAQ scores. Between parents and young adult children, their total CMPB scores were

associated, although a lower correlation. Upon examining the subscales, parent and young adult child deliberate self-harm, aggression, and internet overuse were all moderately associated.

Significantly discrepant findings were discovered in the measurement of experiential avoidance with the AAQ-II and MEAQ. From a basic behavioral perspective, the two-factor theory of avoidance offers a definition that seems conceptually congruent with a more contemporary behavioral conceptualization of experiential avoidance (Hayes, 2004). A two-factor theory informed understanding involves both a respondent conditioning component (aversive private events) as well as an operant component, including direct attempts to alter contact with aversive private events. The key factor that seems to discriminate experiential avoidance, theoretically, is that escape and avoidance behavior are employed in a manner that becomes both chronic and overgeneralized to a multitude of aversive experiences and contexts occasioning them.

Gómez and colleagues (2011) argued that the AAQ and AAQ-II items assess dysfunctional distress and psychological inflexibility, which may be beyond the scope of the experiential avoidance construct. The problems related to the AAQ's internal consistency, although addressed in the AAQ-II, could reflect the measurement of divergent factors. While experiential avoidance is decidedly a maintaining factor in psychological inflexibility, it seems plausible that other propensities (e.g., emotional reactivity and neuroticism) play a role. Experiential avoidance seems necessary, but not sufficient to operate in a way that is deemed psychologically inflexible. Conceptually, the domains measured by the MEAQ differ in the broader content coverage and multifactorial approach to experiential avoidance in comparison to the items of the AAQ-II.

Items included in the AAQ and AAQ-II appear to reflect perceptions of internal experiences or external events rather than behavioral efforts to alter such experiences. One theory that may explain the discrepancies found between MEAQ and AAQ-II scores pertains to construct validity. Provided the discriminant validity from negative emotionality beyond the AAQ and AAQ-II (Gómez et al., 2011), experiential avoidance as measured by the MEAQ may more fully represent a construct consistent with two-factor theory as well as a contemporary behavioral understanding. The MEAQ is a measure of different avoidance strategies that are comprised under experiential avoidance as an umbrella term. Individuals may be more elevated in certain avoidance strategies such as procrastination or behavioral avoidance, but less elevated in other strategies. Individual difference characteristics in avoidance strategies may not be reflected in the composite score and thus may have washed out. Understanding outcomes may better map onto particular avoidance strategies depending on the outcome of interest.

The ACT literature indicates that experiential avoidance becomes particularly deleterious when it interferes with values. Although several items regarding values are included in both measures, it is unclear the extent to which all items were answered in a way that represents this loss of contact with important domains. Furthermore, contexts in which experiential avoidance is employed are not explicitly targeted. Information is thus missing regarding whether self-reported experiential avoidance is context specific or generalized across contexts. Overt problem behaviors are often considered particularly harmful forms of avoidance (Kingston et al., 2010), but there may be more subtle avoidance strategies specific to the individual that simply are not accounted for.

Significant dissimilarities were found in the relevance and measurement of experiential avoidance for outcomes between parents and young adult children. Although hierarchical

multiple linear regression analyses indicated that young adult child and parent AAQ-II scores were the strongest predictors of their own respective posttraumatic stress symptoms and excessive behaviors examined separately, MEAQ scores were not found to be unique contributors in any of the models. Parent AAQ-II scores did not strengthen the predictive model of young adult child experiential avoidance beyond parent and young adult child trauma history, parent posttraumatic stress symptoms, and parent excessive behaviors as initially hypothesized. However, in a model removing young adult child trauma history, young adult child experiential avoidance, and parent excessive behaviors, parent AAQ-II scores were found to predict young adult child experiential avoidance beyond parent trauma history. This model, though significant, was not as strong as expected. As data were not collected from both parents, a complete account of the contribution of parental experiential avoidance could not be included in the model.

Experiential avoidance levels may also be more elevated among a clinical sample. These results seem to illustrate that parent experiential avoidance is a risk factor for young adult child experiential avoidance and that young adult children appeared more resilient than parents in regards to engaging in harmful behavior. Parent posttraumatic stress symptoms were the strongest predictor of young adult child posttraumatic stress symptoms, beyond parent and young adult child trauma history, parent excessive behaviors, and parent experiential avoidance. Polusny and colleagues (2011) also demonstrated that parent PTSD predicted adolescent PTSD beyond parent experiential avoidance. These results replicate this set of findings. Although it was hypothesized that parent posttraumatic stress symptoms would contribute unique variance to the prediction of young adult child posttraumatic stress symptoms, initially it was presumed that parent experiential avoidance would be the most robust predictor. These particular findings suggest that parental posttraumatic stress symptoms are a stronger risk factor for young adult

child posttraumatic stress symptom responses than parent experiential avoidance itself. Given the findings that AAQ-II scores were strong predictors of posttraumatic stress symptoms and excessive behaviors separately for parents and young adults, experiential avoidance may be the key mechanism in understanding individual relationships, while family contextual trauma sequelae trajectories are likely complicated by the influence of multiple factors.

The model predicting young adult child excessive behaviors was non-significant, while parent AAQ-II scores were important predictors of their engagement in excessive behaviors. Implications regarding function of the behavior of interest may help understand this discrepancy. Engagement in excessive behaviors may initiate in the service of negative reinforcement of unwanted private events and may be associated positive reinforcers such as increased social interaction. Over time, continued use of these behaviors could result in deleterious consequences (e.g., legal ramifications for underage drinking). Values may also change over time and excessive behaviors may then be employed as a pervasive pattern of overgeneralized negative reinforcement. Excessive behaviors may be under the stimulus control of certain verbal rules regarding the acceptability of specific behaviors.

Although young adult child AAQ-II scores were associated with their posttraumatic stress symptoms, and parent and young adult child AAQ-II scores served to predict young adult child posttraumatic stress symptoms above and beyond other predictors, excessive behaviors were reported less among young adult children in this sample. It is possible that sample characteristics influenced these results. Young adult children in the sample pool were predominantly high school students. Therefore, it could hold that more restrictions are imposed on their behavior from parents, limiting the opportunity of engagement in problem behavior such as alcohol or drug use. Thus, the outcome that nicotine and drug use linked with AAQ-II and

MEAQ scores in parents, but not in young adult children, supports this notion. Deliberate self-harm was strongly associated with both the AAQ-II and MEAQ, while excessive exercise was strongly negatively correlated with the MEAQ in young adult children. It consequently seems viable that certain behaviors are more readily available to a younger population. It might also hold that parents were simply more honest reporters of their distress and coping mechanisms. Most dyads completed questionnaires near or next to one another, which likely influenced responding to items.

Results from the present study extend findings from a disaster-related trauma exposed sample (Polusny et al., 2011) to a unique convenience and community sample of young adult children and adults, ages 15-70. It is also noteworthy that individual difference characteristics in topography of experiential avoidance were observed when the construct was assessed in a multidimensional manner. This conclusion was drawn from the observation that parent and young adult child experiential avoidance were not significantly associated per the MEAQ total score. Neither were they associated in any of the subscales of the measure.

A behavioral perspective might assert that parents who engage in harmful behaviors may model said behaviors for their children as a form of coping with negative affective states. However, the present study found that only aggression, internet overuse, and deliberate self-harm were associated between parents and young adult children. Deliberate self-harm may be conceptualized as a deficit in distress tolerance. Thus, the strong association between distress aversion, deliberate self-harm, and posttraumatic stress symptoms in parents suggests that distress aversion may serve as one explanatory variable for more proximal outcomes. However, distress aversion levels were not as elevated among young adult children, and parent MEAQ scores were not significant predictors of young adult child experiential avoidance, posttraumatic

stress symptoms, and excessive behaviors. These findings may provide increasing support for the hypothesis that contextual factors impact the utility of avoidance or emotion regulation strategies (Brans, Koval, Verduyn, Lim, & Kuppens, 2013).

Limitations and Future Research

Limitations to the present study foremost include the reliance on a cross-sectional design and the use of self-report assessment instruments to retrospectively assess the variables of interest. The use of a hybrid convenience and community sample may also carry sample characteristics that diverge from that of a clinical sample as previously discussed, thus presenting a limitation in generalizability of findings. It will be important for future studies interested in dyadic associations to employ these investigations among a clinical sample. The differences found between measures of experiential avoidance also provide fruitful evidence that behavioral measures of experiential avoidance are necessary. Measurement discrepancies found in the present study provide even more support for incipient validation of both overt non-verbal behavioral measures as well as behavioral measures of the construct. It will also be necessary to employ these investigations in manners that are more contextually specific. The limited sample size prohibited use of more sophisticated modeling techniques.

Another primary limitation includes a methodological concern. Most parents and their young adult children completed assessment measures in a university setting and were within proximal distance of one another. Expectancy biases and the concern that loved ones may see their responses could have influenced willingness to honestly self-report difficult life experiences, avoidance strategies, as well as distress and problem behaviors. Experiential avoidance is thought to comprise a behavioral unwillingness to be present with distressing private experiences (Hayes, 2004). Thus, individuals who rely most strongly on this response

style may have opted not to participate in the present study. Self-reporting on one's own experiential avoidance may require a degree of awareness with the present moment that seems incongruent to the construct of interest (Thompson & Waltz, 2010). Therefore, behavioral measures incorporating coding and observational means may be one way to address this limitation.

Dyadic members also consisted of one parent and one young adult child. This means that data from both parents were not drawn, and thus a complete picture of dyadic associations could not be represented. A more involved study could build upon these findings through examining individual difference characteristics that incorporate both parents into the picture. Temporal stability of experiential avoidance, posttraumatic stress symptoms, and problem behaviors was also not addressed. Although experiential avoidance is frequently conceptualized as a mediating factor, direction of the association between experiential avoidance and other study variables remains unaddressed and thus longitudinal interventions are necessitated in future studies.

Within a contextual framework, the construct of parental social support post-trauma also seems a relevant concern for future directions. Experiential avoidance among social support systems as a moderator of psychological distress and experiential avoidance levels experienced by trauma survivors after disclosing traumatic events, such as sexual assault, should be explored. It is expected that psychological resilience levels may vary as a function of contextual factors including social support, but this important moderator has not yet been tested within an experiential avoidance framework. This would be an important addition to models of experiential avoidance and posttraumatic stress.

Conclusion

The present study collected data from a sample of parents and young adults in attempts to further understand transmission of experiential avoidance post-trauma and propensity to engage in harmful behaviors. The findings illustrate that one empirically validated measure of experiential avoidance, the AAQ-II, demonstrated utility in predicting posttraumatic stress symptoms and excessive behaviors independently in parents and young adults, while the recently validated MEAQ did not. Experiential avoidance or general psychological inflexibility appear to be risk factors for harmful sequelae experienced by parents and young adults. However, specific avoidance strategies not specifically represented in the data may hold idiographic meaning to predicting harmful outcomes within this population. Parent posttraumatic stress was the strongest predictor and only unique contributor to young adult child posttraumatic stress. Pathways to excessive behaviors and posttraumatic stress symptoms seem to be complex and not fully accounted for by the family context. While parent AAQ-II scores had meaning for predicting young adult AAQ-II scores, this relationship should be further expounded in further studies.

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Table 1

Age, Gender, and Ethnicity Demographics

	Age	Female	Male	White	African American	Mixed Heritage	Chicano/a/Latino/a/Hispanic	Asian American
Parents	46.48 (7.89)	73%	27.6%	68%	18.3%	6.7%	1.7%	1.7%
Young Adult Children	18.38 (3.04)	75%	73%	67%	18.3%	8.3%	5%	1.7%

Table 2

Percentage Data of Potentially Traumatic Events

Items and Dyadic Members	% Endorsed “Happened”	% Endorsed Event as “Most Distressing”
Natural Disaster (for example, fire, hurricane, or flood)		
Parent	18.3% (<i>n</i> = 11)	3.3% (<i>n</i> = 2)
Young Adult Child	3.3% (<i>n</i> = 2)	1.7% (<i>n</i> = 1)
Fire or explosion		
Parent	15% (<i>n</i> = 9)	3.3% (<i>n</i> = 2)
Young Adult Child	3.3% (<i>n</i> = 2)	1.7% (<i>n</i> = 1)
Transportation accident (for example, car accident, boat accident, train wreck, plane crash)		
Parent	76.7% (<i>n</i> = 46)	0% (<i>n</i> = 0)
Young Adult Child	46.7% (<i>n</i> = 28)	5% (<i>n</i> = 3)
Serious accident at work, home, or recreational activity		
Parent	23.3% (<i>n</i> = 14)	3.3% (<i>n</i> = 2)
Young Adult Child	20% (<i>n</i> = 12)	5% (<i>n</i> = 3)
Exposure to toxic substance (for example, dangerous chemicals, radiation)		
Parent	8.3% (<i>n</i> = 5)	0% (<i>n</i> = 0)
Young Adult Child	8.3% (<i>n</i> = 5)	1.7% (<i>n</i> = 1)
Physical assault (for example, being attacked, hit, slapped, kicked, beaten up)		

Parent and Young Adult Child Experiential Avoidance and Traumatic Stress 97

	Parent	21.7% (<i>n</i> = 13)	8.3% (<i>n</i> = 5)
	Young Adult Child	5% (<i>n</i> = 3)	5% (<i>n</i> = 3)
Other unwanted or uncomfortable sexual experience			
	Parent	36.7% (<i>n</i> = 22)	11.7% (<i>n</i> = 7)
	Young Adult Child	18.3% (<i>n</i> = 11)	6.7% (<i>n</i> = 4)
Combat or exposure to a war-zone (in the military or as a civilian)			
	Parent	6.7% (<i>n</i> = 4)	6.7% (<i>n</i> = 4)
	Young Adult Child	0% (<i>n</i> = 0)	0% (<i>n</i> = 0)
Captivity (for example, being kidnapped, abducted, held hostage, prisoner of war)			
	Parent	8.3% (<i>n</i> = 5)	0% (<i>n</i> = 0)
	Young Adult Child	1.7% (<i>n</i> = 1)	0% (<i>n</i> = 0)
Life-threatening illness or injury			
	Parent	30% (<i>n</i> = 18)	18.3% (<i>n</i> = 11)
	Young Adult Child	10% (<i>n</i> = 6)	8.3% (<i>n</i> = 5)
Severe human suffering			
	Parent	6.7% (<i>n</i> = 4)	1.7% (<i>n</i> = 1)
	Young Adult Child	1.7% (<i>n</i> = 1)	3.3% (<i>n</i> = 2)
Sudden, violent death (for example, homicide, suicide)			
	Parent	6.7% (<i>n</i> = 4)	1.7% (<i>n</i> = 1)
	Young Adult Child	6.7% (<i>n</i> = 4)	3.3% (<i>n</i> = 2)
Sudden, unexpected death of someone close to you			
	Parent	48.3% (<i>n</i> = 29)	20% (<i>n</i> = 12)
	Young Adult Child	35% (<i>n</i> = 21)	20% (<i>n</i> = 12)
Serious injury, harm, or death you caused to someone else			
	Parent	6.7% (<i>n</i> = 4)	0% (<i>n</i> = 0)
	Young Adult Child	6.7% (<i>n</i> = 4)	0% (<i>n</i> = 0)
Any other very stressful event or experience			
	Parent	53.3% (<i>n</i> = 32)	13.3% (<i>n</i> = 8)
	Young Adult Child	46.7% (<i>n</i> = 28)	13.3% (<i>n</i> = 8)

Note. Data are based on total endorsed “happened” in response to items.

Table 3

Means, Standard Deviations, and Internal Consistencies for Dyadic Members

Measure	<i>M (SD)</i>		Range		α	
	Parent	Child	Parent	Child	Parent	Child
Experiential Avoidance – MEAQ Total	180(34)	202(32)	105-258	118-269	.909	.834
Experiential Avoidance – AAQ-II Total	17(9)	24(9)	7-42	7-47	.946	.873
Trauma Exposure	4(2)	2(2)	0-10	0-8	.600	.432
Posttraumatic Stress Symptoms	30(13)	38(13)	18-84	17-85	.946	.902
Excessive Behaviors	100(22)	111(24)	59-160	73-159	.836	.827
MEAQ-AAQ-II					.929	.859

Note. LEC data of trauma exposure are based on responses to “happened” questions on the measure only.

	10	11	12	13	14	15	16	17	18	19	20	21
-												
.54**												
.31*	.60**											
.50**	.32*	.08										
.07	.14	-.43**	.11									
.20	.73**	.57**	-.07	-.08								
.06	.32*	-.12	-.03	.05	.06							
.29*	.71**	.45**	.06	.01	.56**	.05						
.08	.20	-.08	-.18	.27*	.06	-.20	.31*					
.16	.57**	.41**	-.06	.09	.50**	.08	.44**	.06				
.38**	.52**	.33*	.31*	.03	.22	-.00	.10	-.01	.17			
.28*	.45**	.09	.49**	.00	.07	.11	.24	-.18	.06	.30*		

Table 4

Bivariate Correlations of Study Variables for Young Adult Child Participants

	1	2	3	4	5	6	7	8	9
1) Experiential Avoidance – MEAQ	-								
2) Behavioral Avoidance Subscale - MEAQ	.77**	-							
3) Distress Avoidance Subscale - MEAQ	.77**	.60**	-						
4) Procrastination Subscale - MEAQ	.68**	.39**	.36**	-					
5) Distraction and Suppression Subscale -	.26*	.30*	.14	-.06	-				
6) Repression and Denial Subscale -	.57**	.21	.33**	.25*	.06	-			
7) Distress Endurance Subscale - MEAQ	-.63**	-.40**	-.24	-.61**	.10	-.20	-		
8) Experiential Avoidance – AAQ-II	.45**	.14	.30*	.52**	-.12	.43**	-.32*	-	
9) Trauma Exposure – LEC	.03	.02	.01	-.06	-.07	.13	-.06	.04	-
10) PTSD Symptom Severity – PCL-C	.24	-.03	.10	.30*	-.02	.44**	-.06	.66**	.12
11) Excessive Behaviors - CMPB	.03	-.15	.06	.18	-.28*	.27*	.07	.43**	.07
12) Nicotine Use Subscale - CMPB	-.05	-.13	.03	-.01	-.28*	.14	.10	.16	.25*
13) Deliberate Self-Harm Subscale -	.33**	.17	.31*	.32*	-.10	.23	-.19	.49**	.12
14) Internet Overuse Subscale - CMPB	-.02	.13	-.09	.36**	.07	.03	-.20	.18	-.16
15) Drug Use Subscale - CMPB	.15	-.15	.08	.04	-.29*	.16	.16	.18	.00
16) Excessive Exercise Subscale - CMPB	-.37**	-.42**	-.15	-.21	-.16	.06	.32*	-.04	-.06
17) Alcohol Use Subscale - CMPB	.03	-.06	.07	-.01	-.16	.26*	.07	.33**	.05
18) Binge Eating Subscale – CMPB	-.02	-.11	-.19	.08	-.06	.16	-.06	.09	.06
19) Sexual Promiscuity Subscale - CMPB	.01	-.04	-.06	.06	-.15	.23	.01	.17	.03
20) Aggression Subscale - CMPB	.01	-.07	.12	.09	-.16	.08	.12	.26*	.20
21) Restrictive Eating Subscale - CMPB	.19	.08	.23	.15	.05	.15	-.02	.29*	-.07

Note. N = 60, *p < .05, **p < .01

	9	10	11	12	13	14	15	16	17	18	19	20	21
-													
.19	-												
.22	.59**	-											
.34**	.23	.51**	-										
-.08	.35**	.46**	.13	-									
.05	.35**	.58**	.23	.15	-								
.20	.50**	.66**	.41**	.38**	.13	-							
-.05	.07	.29*	-.13	-.07	.04	.06	-						
.15	.32*	.63**	.24	.38**	.12	.31*	.34**	-					
-.15	.08	.39**	.10	.06	.29*	.16	-.05	.15	-				
.36**	.22	.55**	.23	.21	.33**	.40**	-.02	.26*	.19	-			
.24	.64**	.59**	.21	.28*	.47**	.32*	-.13	.23	.23	.37**	-		
-.15	.34**	.33**	-.19	.27*	.27*	.07	.27*	.23	.22	-.07	-.03	.17	-

Table 5
Bivariate Correlations of Study Variables for Parent Participants

	1	2	3	4	5	6	7	8
1) Experiential Avoidance – MEAQ	-							
2) Behavioral Avoidance Subscale - MEAQ	.88**	-						
3) Distress Aversion Subscale - MEAQ	.78**	.72**	-					
4) Procrastination Subscale - MEAQ	.64**	.52**	.26*	-				
5) Distraction and Suppression Subscale - MEAQ	.65**	.66**	.63**	.19	-			
6) Repression and Denial Subscale - MEAQ	.64**	.37**	.34**	.41**	.18	-		
7) Distress Endurance Subscale - MEAQ	-.38**	-.25*	-.02	-.24	-.01	-.16	-	
8) Experiential Avoidance – AAQ-II	.60**	.53**	.45**	.65**	.20	.42**	-.09	-
9) Trauma Exposure – LEC	.04	.01	.18	-.00	-.14	.09	.08	.03
10) PTSD Symptom Severity – PCL-C	.47**	.39**	.40**	.38**	.24	.43**	.02	.65**
11) Excessive Behaviors – CMPB	.38**	.20	.22	.47**	.04	.55**	.01	.59**
12) Nicotine Use Subscale – CMPB	.35**	.27*	.23	.35**	.07	.39**	-.06	.37**
13) Deliberate Self-Harm Subscale – CMPB	.32*	.26*	.25*	.21	.08	.26*	-.18	.44**
14) Internet Overuse Subscale – CMPB	.30*	.19	.09	.47**	-.08	.40**	-.09	.44**
15) Drug Use Subscale – CMPB	.41**	.30*	.33**	.25	.23	.42**	-.03	.36**
16) Excessive Exercise Subscale – CMPB	-.23	-.23	-.16	-.21	-.16	.07	.31*	-.08
17) Alcohol Use Subscale - CMPB	.09	-.10	.06	.25	-.09	.23	-.08	.33**
18) Binge Eating Subscale – CMPB	.07	.02	-.06	.23	.09	.15	.13	.13
19) Sexual Promiscuity Subscale - CMPB	.07	-.090	-.01	.23	-.10	.26*	.05	.14
20) Aggression Subscale - CMPB	.36**	.23	.32*	.39**	.11	.35**	.04	.48**
21) Restrictive Eating Subscale - CMPB	.29*	.27*	.20	.22	.23	.18	-.16	.41**

Note. N = 60, *p < .05, **p < .01

Table 6

Bivariate Correlations of Study Variables Between Dyadic Members

	1	2	3	4	5	6	7	8
Parents	Young Adult Children							
1) Experiential Avoidance – MEAQ	-.08	-						
2) Behavioral Avoidance Subscale - MEAQ	.03	.03	-					
3) Distress Aversion Subscale - MEAQ	.14	.23	.14	-				
4) Procrastination Subscale - MEAQ	.24	-.08	-.12	.24	-			
5) Distraction and Suppression Subscale -	-.10	.10	.00	-.09	-.10	-		
6) Repression and Denial Subscale - MEAQ	.12	-.15	-.08	-.07	.00	.12	-	
7) Distress Endurance Subscale - MEAQ	.07	.08	-.00	-.03	-.02	.16	.07	-
8) Experiential Avoidance – AAQ-II	.01	.08	.07	.09	.01	-.12	.07	.27*
9) Trauma Exposure – LEC	-.00	-.00	-.01	-.00	.12	.01	.05	.15
10) PTSD Symptom Severity – PCL-C	.04	.15	.11	-.08	.13	-.07	.06	.13
11) Excessive Behaviors – CMPB	-.20	-.19	-.16	-.18	.02	-.04	.16	.15
12) Nicotine Use Subscale – CMPB	-.22	-.15	-.24	-.14	.04	-.05	.20	-.07
13) Deliberate Self-Harm Subscale – CMPB	-.04	-.08	.11	.07	-.27*	-.05	.07	.22
14) Internet Overuse Subscale – CMPB	.01	.08	-.09	.02	-.02	-.05	-.12	.23
15) Drug Use Subscale – CMPB	-.14	-.12	.05	-.18	.06	-.06	.30*	-.03
16) Excessive Exercise Subscale – CMPB	.12	-.02	.10	-.10	.25	.23	-.04	.07
17) Alcohol Use Subscale - CMPB	-.08	-.12	-.07	-.06	-.00	.04	.09	.10
18) Binge Eating Subscale – CMPB	-.30*	-.27*	-.32*	-.09	-.29*	-.16	.01	-.01
19) Sexual Promiscuity Subscale - CMPB	-.19	-.22	-.19	-.05	-.01	-.12	.07	.20
20) Aggression Subscale - CMPB	-.11	-.04	-.04	-.04	-.12	-.14	.07	.17
21) Restrictive Eating Subscale - CMPB	-.06	-.02	.02	-.19	.14	.02	.17	.04

Note. N = 120, *p < .05, **p < .01

Table 7

Summary of Hierarchical Linear Regression Predicting Parent Posttraumatic Stress Symptoms

Block	Variable	B	SE B	β	t	R ²	R ² Δ	F
1	Parent trauma exposure					.037	.037	2.247
Measure	LEC	.013	.009	.193	1.499			
2	Parent experiential avoidance					.463	.426	16.091***
Measure	LEC	.011	.006	.166	1.688			
	AAQ-II	.010	.002	.572	4.660***			
	MEAQ	.001	.001	.122	.997			

Note. * $p < .05$, ** $p < .01$, *** $p < .001$.

Table 8

Summary of Hierarchical Linear Regression Predicting Parent Excessive Behaviors

Block	Variable	B	SE B	β	t	R ²	R ² Δ	F
1	Parent trauma exposure					.049	.049	3.019
Measure	LEC	2.073	1.193	.222	1.737			
2	Parent experiential avoidance					.463	.426	15.866***
Measure	LEC	1.851	.971	.199	1.906			
	AAQ-II	1.344	.313	.560	4.290***			
	MEAQ	.029	.086	.043	.333			

Note. * $p < .05$, ** $p < .01$, *** $p < .001$.

Table 9

Summary of Hierarchical Linear Regression Predicting Young Adult Child Posttraumatic Stress Symptoms

Block	Variable	<i>B</i>	<i>SE B</i>	β	<i>t</i>	<i>R</i> ²	<i>R</i> ² Δ	<i>F</i>
1	Young adult child trauma exposure					.030	.030	1.784
Measure	LEC	.013	.010	.173	1.336			
2	Young adult child experiential avoidance					.370	.340	15.866***
Measure	LEC	.012	.008	.152	1.435			
	AAQ-II	.010	.002	.618	5.278***			
	MEAQ	.000	.001	-.097	-.825			

Note. * $p < .05$, ** $p < .01$, *** $p < .001$.

Table 10

Summary of Hierarchical Linear Regression Predicting Young Adult Child Excessive Behaviors

Block	Variable	<i>B</i>	<i>SE B</i>	β	<i>t</i>	<i>R</i> ²	<i>R</i> ² Δ	<i>F</i>
1	Young adult child trauma exposure					.004	.004	.219
Measure	LEC	.738	1.577	.061	.468			
2	Young adult child experiential avoidance					.261	.257	6.584***
Measure	LEC	.579	1.384	.048	.418			
	MEAQ	-.162	.091	-.225	-1.771			
	AAQ-II	1.423	.323	.559	4.411***			

Note. * $p < .05$, ** $p < .01$, *** $p < .001$.

Table 11

Summary of Hierarchical Linear Regression Predicting Young Adult Child Experiential Avoidance

Block	Variable	<i>B</i>	<i>SE B</i>	β	<i>t</i>	<i>R</i> ²	<i>R</i> ² Δ	<i>F</i>
1	Parent trauma exposure					.024	.024	1.407
Measure	LEC	.596	.502	.154	1.186			
2	Young adult child experiential avoidance					.095	.071	2.981*
Measure	LEC	.555	.488	.143	1.137			
	AAQ-II	.266	.126	.267	2.115*			

Note. * $p < .05$, ** $p < .01$, *** $p < .001$, criterion variable assessed using AAQ-II.

Table 12

Summary of Hierarchical Linear Regression Predicting Young Adult Child Posttraumatic Stress Symptoms from Parent and Young Adult Child Variables

Block	Variable	<i>B</i>	<i>SE B</i>	β	<i>t</i>	<i>R</i> ²	<i>R</i> ² Δ	<i>F</i>
1	Parent trauma exposure	.668	.757	.119	.883	.064	.064	1.953
	Young adult child trauma history	1.310	.925	.191	1.417			
2	Parent posttraumatic stress symptoms	.315	.135	.300	2.329*	.147	.083	3.212*
3	Parent excessive behaviors	.016	.095	.026	.168	.147	.000	.028
4	Parent experiential avoidance							
	AAQ-II	.168	.289	.116	.582			
	MEAQ	.017	.064	.043	.266			

Note. * $p < .05$, ** $p < .01$, *** $p < .001$.

Table 13

Summary of Hierarchical Linear Regression Predicting Young Adult Child Aggression

Block	Variable	<i>B</i>	SE <i>B</i>	β	<i>t</i>	<i>R</i> ²	<i>R</i> ² Δ	<i>F</i>
1	Young adult child trauma exposure	.354	.333	.144	1.065	.050	.050	1.485
	Parent trauma exposure	.263	.272	.131	.968			
2	Parent Posttraumatic stress symptoms	.055	.050	.148	1.099	.070	.020	1.396
3	Parent excessive behavior subscales					.386	.317	2.022*
	Nicotine use	9.819	4.232	1.909	2.320*			
	Deliberate self-harm	8.929	3.278	.798	2.724**			
	Drug use	8.085	3.676	1.029	2.200*			
	Alcohol use	10.708	3.734	1.686	2.868**			
	Internet overuse	1.474	.581	1.579	2.538**			
	Excessive exercise	1.359	.577	1.556	2.355*			
	Binge eating	1.226	.617	1.035	1.986*			
	Sexual promiscuity	1.535	.646	1.248	2.374*			

	Aggression	1.674	.607	1.335	2.760**		
	Restrictive eating	2.011	.661	1.430	2.540*		
4	Parent experiential avoidance					.414	.027
	AAQ-II	.132	.117	.255	1.132		
	MEAQ	-.028	.025	-.199	-1.144		

Note. * $p < .05$, ** $p < .01$, *** $p < .001$.

Appendix A

EMU UHSRC#1203 Approved

Instructor Oral Recruitment Script

The Student Investigator, Meaghan Lewis, for a research project entitled, “*An Examination of Experiential Avoidance as a Vulnerability Factor for Posttraumatic Stress Symptoms and Excessive Behaviors in Parent and Adult Child Dyads*” would like to invite you and your parent or former primary caregiver to participate in a research study that is being conducted through the Eastern Michigan University (EMU) psychology department. This project will serve as Meaghan Lewis’ thesis project in partial fulfillment of the requirements of a Master of Science degree in Clinical Behavioral Psychology.

This study proposes to look at the relationships among certain stressful life events, responses to these events, and different behaviors that could be linked with these events in adult children and their parents. This research study will take place online using *SONA* systems through the Survey Monkey website. Students enrolled in introductory psychology courses are eligible to participate if they have a parent whose contact information the student could provide.

Parents will be contacted via email or postal mail by the Student Investigator and provided with a link to the online survey or a paper and pencil version and instructed to mail back the completed survey to the Faculty Investigator, Dr. Tamara Loverich.

Research participants will respond to six self-report measures that are estimated to require approximately 30 minutes of time. On the first page of the survey, adult child participants (EMU students) will input their parent or former primary caregiver's email or postal mailing address. In exchange for parent and adult child participation, EMU students may receive extra credit through *SONA* systems. Depending on your instructor, it may be possible to apply this extra credit to your course. In addition, students will be compensated with a *small gift card* for participation. However, the Student Investigator must receive the completed online survey from both the adult child and the parent to be eligible for this compensation. It is anticipated that these questionnaires will help researchers explore whether certain emotional response styles or ways of coping and behaviors are related to difficult life experiences.

Participation in this study is completely voluntary and there will be no penalty to yourself, your parent, or your relationship with the Eastern Michigan University Psychology Department if you choose not to participate or would like to withdraw your participation during the study. In addition, you may choose not to answer any questions that make you feel uncomfortable. Names will be collected only through *SONA* extra credit management and to ensure the parent has also participated, so credit may be awarded to the student. No names will be linked with any of the responses. If parents do not respond within a two week period, a reminder email or postcard will be sent. Only study staff has access to the information collected throughout the duration of this study and all responses are completely confidential and will not be shared with the parent or former primary caregiver. Conversely, parents or former primary

caregivers' responses will not be shared with the adult child. Confidential identification numbers will be attached by the Student Investigator to participant responses with one identical character for adult child and parent for the purposes of data analyses. If you are interested in participating in this project, please talk with your parent or former primary caregiver about their interests and willingness to participate, and visit the link to *SONA* systems provided by your instructor. Should you have any questions or concerns either now or during the completion of the present study, please contact the Student Investigator, Meaghan Lewis at mlewis64@emich.edu or the Faculty Investigator, Dr. Tamara Loverich at tpenix@emich.edu or (734) 487-3228. This contact information will also be provided in the informed consent document online. The study investigators would like to thank you for your time and consideration.

Appendix B

Recruitment Fliers

EMU UHSRC#1203 Approved

Seeking Research Participants

Clinical researchers in the EMU Psychology Department are in need of individuals for participation in an online survey examining certain distressing life experiences, responses to these experiences, and problems that could be related in *young adult children and their parents*.

You may be eligible if have a *parent* who may also be willing to complete an online survey, and are interested in participating in this study.

To learn more about participating in this study, please contact

Meaghan Lewis at mlewis64@emich.edu

All answers to questionnaires are kept completely confidential.

Thank you and have a good day! Please visit the link to participate.

https://www.surveymonkey.com/s/JB3TWF5 contact: mlewis64@emich.edu for questions	https://www.surveymonkey.com/s/JB3TWF5 contact: mlewis64@emich.edu for questions
https://www.surveymonkey.com/s/	https://www.surveymonkey.com/s/J

B3TWF5 contact: mlewis64@emich.edu for questions	B3TWF5 contact: mlewis64@emich.edu for questions
https://www.surveymonkey.com/s/J B3TWF5 contact: mlewis64@emich.edu for questions	https://www.surveymonkey.com/s/J B3TWF5 contact: mlewis64@emich.edu for questions
contact: mlewis64@emich.edu for questions	contact: mlewis64@emich.edu for questions

Appendix C

Informed Consent for Research Participation

Eastern Michigan University

Department of Psychology

EMU UHSRC#1203 Approved

Faculty Investigator: Tamara M. Loverich, Ph.D.

Student Investigator: Meaghan M. Lewis, B.S.

Title of Study: *“Investigating the Role of Experiential Avoidance and Excessive Behaviors in Response to Stressful Situations in Parents and Young Adult Children”*

Dear Research Participants,

Thank you for considering participating in our study. You are invited to participate in a research project intended to investigate particular life events in parents and their adult children, reactions to these events, and behaviors that could be influenced by these events. This project will serve as Meaghan Lewis' thesis project in partial fulfillment of the requirements of a Master of Science degree in Clinical Behavioral Psychology. The purpose of this consent document is to highlight the overarching goal of this research project as well as the time commitments, procedures involved, and risks and benefits of your participation. Please read this document carefully. We are contactable via email at mlewis64@emich.edu and tpenix@emich.edu or via phone at (734) 487-3228 should you have any further questions that aren't addressed in this consent document.

Participation Eligibility, Purpose of Our Study, and Time Commitment

You are eligible for participation if you have a parent (or are the parent of an adult child) who could also participate in this study. If you choose to participate, you will be asked to complete six questionnaires regarding distressing life events that sometimes happen to people, reactions to these events, emotional/coping responses, and questions about behaviors such as substance use, eating habits, sexual behavior, internet use, and aggression. You will also be asked to fill out demographic information. Participation will require approximately 30 minutes to complete the survey. Participation will take place on *SONA* systems through the Survey Monkey website online at Eastern Michigan University.

Both parents and their adult children are encouraged to participate in our study as we will need information from both dyads to have a more complete understanding of this relationship. However, *participation is completely voluntary participation is completely voluntary and you may choose not to participate or withdraw at any time without any penalty.* The investigators may also choose to stop your participation in this study without your consent.

Risks and Benefits of Participation

There are no apparent risks of participating in the current study; however, it is possible that some of the questions may trigger distressing reactions. If this becomes a problem, you may withdraw your participation. You may also skip any questions you do not wish to answer. Should you feel a need to seek professional mental health services, please contact the Eastern Michigan University Psychology Clinic, located at 611 West Cross Street, Ypsilanti, MI 48197, Phone Number: 734-487-4987. You may also contact Eastern Michigan University (EMU) Counseling and Psychological Services (CAPS) located at 313 Snow Health Center, Ypsilanti, MI 48197, Phone Number: (734) 487-1118. Services are free to EMU students.

To compensate you for your time participating, we will provide a gift card in the amount of five dollars. There are no direct benefits for your participation, but the information acquired from your participation may help promote an increased understanding of reactions to distressing life events. It may also assist with the development of more effective interventions for problems some people experience coping with distressing events. Results of our investigation will be disseminated for publication in scholarly journals, and presentation at research conferences with no names attached to this information. The results will appear in group format so that no individual responses are identifiable. If you are interested in the results of this study, let us know, and we will send a copy as soon as the results are analyzed.

Confidentiality

Your answers to questions on the questionnaires are completely confidential. No names will be associated with any of the data we gather. At the end of the survey, we will provide you with a link to a separate server to receive the gift card. This will require you to submit your name; however, you will be protected in that your name will not be associated with study data in any way. If recruited from Explore Eastern Day, please disregard this, as gift cards will be provided by the Student Investigator or a trained research assistant. The student investigator will keep a master list with confidential identification numbers associated with the parents and adult children dyads for data analysis purposes, these are numbers used to de-identify your responses. The master list will be stored in a password protected computer in the research laboratory of Dr. Tamara Loverich. This ID number will be generated by the student investigator. Aside from your time participating, there are no anticipated costs involved with participating in our research.

This research protocol and consent document has been approved by the Eastern Michigan University Human Subjects Institutional Review Board from 9/30/2013 to 9/29/2014. *Do not participate in this study if the date is older than one year.* If you have questions about this consent document or the present study, contact the student investigator or faculty investigator at the contact information provided in the beginning of this document. You may also contact the Chair, Human Subjects Institutional Review Board, Dr. Alissa Huth-Bocks at (734) 487-0112 or via email at ahuthboc@emich.edu.

I have read the informed consent document and understand the terms to which my participation will entail.

By checking this box, I indicate that I have read the terms that my participation will entail and give my consent to participate in this study.

I agree to participate in this study.

Appendix D

Recruitment Method I

Demographic Questionnaire

Reminder to parents: Giftcard compensation will be provided to young adult/adult children should you agree and submit responses to this survey

1. Please provide email contact information for your parent/guardian or primary caregiver (if email not applicable, please provide a mailing address)
2. Please indicate if you participated in this study online (recruited from Psychology Course) or at the Explore Eastern day:

Psychology Course ___

Explore Eastern Day ___

3. How old are you? _____Years

4. Gender

- Female
- Male
- Transgender

5. Ethnicity

- African-American/Black
- Asian or Asian American
- Chicano/a/Latino/a/Hispanic
- European American or White
- Pacific Islander or PI American
- Middle Eastern or Arab American
- Mixed Heritage
- Other

6. Relationship status

- Divorced, not remarried
- Living with partner

- Married
- Married with children
- Remarried
- Single, never married, not living with partner
- Remarried
- Widowed
- Other

7. Annual household income (income for self – parent; income for family of origin – adult child)

- <\$10,000
- \$11,000-24,000
- \$25,000-49,000
- \$50,000-74,000
- \$75,000-99,000
- \$100,000-250,000
- >\$250,000

8. Educational status

- Did not graduate high school
- GED
- Some college
- Bachelor's degree
- Master's degree
- Doctorate or equivalent in my field

Appendix E

Parent Recruitment Script

EMU UHSRC#1203 Approved

Dear parent of an Eastern Michigan University introductory psychology student,

This purpose of this message is to inform you that your adult child college student has provided your contact information for potential participation in a research study that is being conducted through the Psychology Department. If your child has discussed this opportunity with you, we would like to thank you for allowing them to provide your contact information. The Student Investigator, Meaghan Lewis, would like to invite you to participate in a research project. This project will serve as Meaghan Lewis' thesis project in partial fulfillment of the requirements of a Master of Science degree in Clinical Behavioral Psychology.

The purpose of this research project is to explore the relationships among certain stressful life events, responses to these events, and different behaviors that could be linked with these events in adult children and their parents. If you are receiving this message, this means that your student has already completed an online survey through *SONA* systems and the Survey Monkey website. Your research participation is being requested. Research participants will respond to six questionnaires that are estimated to require approximately 30 minutes. Should you choose to participate, your college student will be compensated with extra credit and a gift card once your responses to the questionnaires are received.

There are no foreseeable risks for participating in the present study. Participation in this study is completely voluntary and there will be no penalty to yourself, your child, or your relationship with the Eastern Michigan University Psychology Department if you choose not to

participate or would like to withdraw your participation during the study. In addition, you may choose not to answer any questions that make you feel uncomfortable. Names will be collected only through *SONA* extra credit management for students interested in course credit. No names will be linked with any of the responses. If you do not respond within a two week period, a reminder email or postcard will be sent. Only study staff has access to the information collected throughout the duration of this study and all responses are completely confidential and will not be shared with the parent or former primary caregiver. Conversely, parents or former primary caregivers' responses will not be shared with the adult child. Confidential identification numbers will be attached by the Student Investigator to participant responses with one identical character for adult child and parent for the purposes of data analyses. If you are interested in participating in this project, please visit the link to *SONA* systems embedded in the end of this document.

Should you have any questions or concerns either now or during the completion of the present study, please contact the Student Investigator, Meaghan Lewis at mlewis64@emich.edu or the Faculty Investigator, Dr. Tamara Loverich at tpenix@emich.edu or (734) 487-3228. This contact information will also be provided in the informed consent document online. The study investigators would like to thank you for your time and considering participating.

If you have received this script via postal mail, please mail the *signed* informed consent document as well as the completed survey to:

Dr. Tamara Loverich
Department of Psychology
341 Science Complex
Eastern Michigan University
Ypsilanti, MI 48197

Thanks so much for considering participating in our project,

Sincerely,

Meaghan Lewis & Tamara Loverich, Ph.D.

Please follow the link below to complete our online survey.

Appendix F

Recruitment Handouts

EMU UHSRC#1203 Approved

**Parent-Young Adult Child Experiential Avoidance and Trauma
Research**

Clinical researchers in the EMU Psychology Department are in need of parents and their adult children (EMU students or potential EMU students) attending the Explore Eastern Day for participation in an online survey examining certain distressing life experiences, responses to these experiences, and problems that could be related in *young adult children and their parents*. You are eligible to participate if you are the parent of a young adult child, or are 17-years-old or older and have a parent who is also interested in participating. Survey completion requires approximately 30 minutes of your time and is done online. Research participants will be compensated with a gift card for participation! Email Meaghan Lewis at mlewis64@emich.edu should you have questions or concerns. Thanks for your time!

Parent-Young Adult Child Experiential Avoidance and Trauma Research

Clinical researchers in the EMU Psychology Department are in need of parents and their adult children (EMU students or potential EMU students) attending the Explore Eastern Day for participation in an online survey examining certain distressing life experiences, responses to these experiences, and problems that could be related in *young adult children and their parents*. You are eligible to participate if you are the parent of a young adult child, or are 17-years-old or older and have a parent who is also interested in participating. Survey completion requires approximately 30 minutes of your time and is done online. Research participants will be compensated with a gift card for participation! Email Meaghan Lewis at mlewis64@emich.edu should you have questions or concerns. Thanks for your time!

Parent- Young Adult Child Experiential Avoidance and Trauma Research

Clinical researchers in the EMU Psychology Department are in need of parents and their adult children (EMU students or potential

EMU students) attending the Explore Eastern Day for participation in an online survey examining certain distressing life experiences, responses to these experiences, and problems that could be related in *young adult children and their parents*. You are eligible to participate if you are the parent of a young adult child, or are 17-years-old or older and have a parent who is also interested in participating. Survey completion requires approximately 30 minutes of your time and is done online. Research participants will be compensated with a gift card for participation! Email Meaghan Lewis at mlewis64@emich.edu should you have questions or concerns. Thanks for your time!

Appendix G

Recruitment Script for Explore Eastern Day

EMU UHSRC#1203 Approved

Hello, my name _____ and I am a research assistant in the Clinical Psychology Department at Eastern Michigan University. I would like to invite you to have your first research experience through participating in a research study that is being conducted here, it will require less than 30 minutes of your time, and you will be compensated with a gift card for participating.

This study will serve as Meaghan Lewis' master's thesis project, looking at certain stressful life events and ways in which parents and their children respond to these events. To participate, *we need both a parent and young adult or adult child (can be 17-years-old)*. Participation will require completing six questionnaires online in the reserved computer laboratory here in the Student Center. All answers are completely confidential and will not influence your admissions to the university in any way, nor will they be linked with your student records should you choose to come here. Answers from parents and children will not be shared with one another. You will never be asked to provide your name, so it is impossible for your name to be linked with any of the information you provide.

Through participating, it is hoped that clinical researchers will more fully understand emotional responses to stressful life events, the role of avoidance, certain behaviors that could be influenced by these events, and the relationship between emotional responding to stressful events *in parents and young adults*. We are also hoping that potential EMU students will get an idea of what research is like and if they would like to be involved in various aspects of research as a future student.

There are no anticipated risks of participating, but in the event that any of the items on the questionnaires cause distress, please let us know so we can make appropriate referrals. Dr. Tamara Loverich, the Co-Primary Investigator, is a Licensed Clinical Psychologist and she will also be available to contact should this happen. You may also discontinue the study at any time without penalty and you are not required to answer any questions that make you feel uncomfortable.

If potential participant agrees:

Thank you for agreeing to participate.

Research Assistant - assign confidential ID numbers using ID tabs

Research Assistant - Escort to computer lab

When participant dyad (both parent and adult child) completes study, provide the gift card and thank for their contribution.

If potential participants are interested, but not right now:

Please say the following: If you cannot participate right now, please consider coming back later.

We will be here until 2pm.

Also ask if interested in participating from home. Give handout information with link to survey and thank for consideration. Try, if possible, to get them to participate sometime later during the event. (But, if possible we want participants to participate today!) Provide packet of information.

If not interested in packet:

Thank for stopping to talk with us.

Appendix H

Assent for Research Participation

Eastern Michigan University

Department of Psychology

EMU UHSRC#1203 Approved

Faculty Investigator: Tamara M. Loverich, Ph.D.

Student Investigator: Meaghan M. Lewis, B.S.

Title of Study: *“Investigating the Role of Experiential Avoidance and Excessive Behaviors in Response to Stressful Situations in Parents and Young Adult Children”*

Dear Research Participant and Parent of Participant,

Thank you for considering participating in our study. You are invited to participate in a research project intended to investigate particular life events in parents and their adult children, reactions to these events, and behaviors that could be influenced by these events. This project will serve as Meaghan Lewis' thesis project in partial fulfillment of the requirements of a Master of Science degree in Clinical Behavioral Psychology. The purpose of this consent document is to highlight the overarching goal of this research project as well as the time commitments, procedures involved, and risks and benefits of your participation. Please read this document carefully. We are contactable via email at mlewis64@emich.edu and tpenix@emich.edu or via phone at (734) 487-3228 should you have any further questions that aren't addressed in this consent document.

Participation Eligibility, Purpose of Our Study, and Time Commitment

You are eligible for participation if you have a parent who could also participate in this study and if your parent agrees to allow your participation. If you choose to participate, you will be asked to complete six questionnaires regarding distressing life events that sometimes happen to people, reactions to these events, emotional/coping responses, and questions about behaviors such as substance use, eating habits, sexual behavior, internet use, and aggression. You will also be asked to fill out demographic information. Participation will require approximately 30 minutes to complete the survey. Participation will take place on *SONA* systems through the Survey Monkey website online at Eastern Michigan University on the Explore Eastern Day on October 5, 2013.

Both parents and their adult children are encouraged to participate in our study as we will need information from both individuals to have a more complete understanding of this relationship. However, *participation is completely voluntary and you may choose not to participate or withdraw at any time without any penalty.* The investigators may also choose to stop your participation in this study without your consent.

Risks and Benefits of Participation

There are no apparent risks of participating in the current study; however, it is possible that some of the questions may trigger distressing reactions. If this becomes a problem, you may withdraw your participation. You may also skip any questions you do not wish to answer. Should you feel a need to seek professional mental health services, please contact the Eastern Michigan University Psychology Clinic, located at 611 West Cross Street, Ypsilanti, MI 48197, Phone Number: 734-487-4987. You may also contact Eastern Michigan University (EMU) Counseling

and Psychological Services (CAPS) located at 313 Snow Health Center, Ypsilanti, MI 48197, Phone Number: (734) 487-1118. Services are free to EMU students.

To compensate you for your time participating, we will provide a gift card in the amount of five dollars. In order to receive the gift cards, both adult child and parent must participate. There are no direct benefits for your participation, but the information we acquire from your participation may help promote increased understanding of reactions to distressing life events. It may also assist with the development of effective interventions for problems some people experience coping with distressing events. Results of our investigation will be disseminated for publication in scholarly journals, and presentation at research conferences with no names attached to this information. The results will appear in group format so that no individual responses are identifiable. If you are interested in the results of this study, let us know, and we will send you a copy once the results have been analyzed.

Confidentiality

Your answers to questions on the questionnaires are completely confidential. No names will be associated with any of the data we gather. At the end of the survey, we will provide you with a link to a separate server to receive the gift card. This will require you to submit your name; however, you will be protected in that your name will not be associated with study data in any way. If recruited from Explore Eastern Day, please disregard this, as gift cards will be provided by the Student Investigator or a trained research assistant. The student investigator will keep a master list with confidential identification numbers associated with the parents and adult children dyads for data analysis purposes, these are numbers used to de-identify your responses. The master list will be stored in a password protected computer in the research laboratory of Dr.

Tamara Loverich. This ID number will be generated by the student investigator. Aside from your time participating, there are no anticipated costs involved with participating in our research.

This research protocol and consent document has been approved by the Eastern Michigan University Human Subjects Institutional Review Board from 9/30/2013 to 9/30/2014. *Do not participate in this study if the date is older than one year.* If you have questions about this assent document or the present study, contact the student investigator or faculty investigator at the contact information provided in the beginning of this document. You may also contact the Chair, Human Subjects Institutional Review Board, Dr. Alissa Huth-Bocks at (734) 487-0112 or via email at ahuthboc@emich.edu.

I have read this assent document and understand the terms to which my participation will entail.

Click here if you agree to participate in this study.

—

Appendix I

Recruitment Method II

Demographic Questionnaire

Reminder to parents: your child will be compensated with a giftcard should you agree and submit a response to this survey

1. Please indicate if you participated in the study online (recruited from Psychology Course) or Explore Eastern day:

Psychology Course ___

Explore Eastern Day ___

2. Check One:

Parent

Adult Child

3. How old are you?

_____Years

4. Gender

Female

Male

Transgender

5. Ethnicity

African-American/Black

Asian or Asian American

Chicano/a/Latino/a/Hispanic

European American or White

Pacific Islander or PI American

Middle Eastern or Arab American

Mixed Heritage

Other

6. Relationship status

- Divorced, not remarried
- Living with partner
- Married
- Married with children
- Remarried
- Single, never married, not living with partner
- Remarried
- Widowed
- Other

7. Annual household income (income for self – parent; income for family of origin – adult child)

- <\$10,000
- \$11,000-24,000
- \$25,000-49,000
- \$50,000-74,000
- \$75,000-99,000
- \$100,000-250,000
- >\$250,000

8. Educational status

- Did not graduate high school
- GED
- Some college
- Bachelor's degree
- Master's degree
- Doctorate or equivalent in my field

Appendix J

Debriefing Form

Thank you for participating in this study. The purpose of this research was to better understand the relationship between parent and child emotional functioning, various behaviors, and the influence of stressful life events on emotions and behavior. Another aim was to determine whether a certain emotional regulation style could lead to increased stress symptoms after traumatic experiences.

If any of the items on the questionnaires caused you to experience distress, contact information is provided below to access mental health services. You may also contact the Co-Primary Investigator, Dr. Tamara Loverich.

Please visit the next page where information is provided on how to obtain a gift card for participation.

Referral Resources:

EMU Counseling and Psychological Services, Phone Number: (734) 487-1118

Tamara Loverich, Ph.D., Phone Number: (734) 487-3228, Email: tpenix@emich.edu

Appendix K

Multidimensional 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. I won't do something if I think it will make me uncomfortable | 1 2 3 4 5 6 |
| 2. If I could magically remove all of my painful memories, I would | 1 2 3 4 5 6 |
| 3. When something upsetting comes up, I try very hard to stop thinking about it | 1 2 3 4 5 6 |
| 4. I sometimes have difficulty identifying how I feel | 1 2 3 4 5 6 |
| 5. I tend to put off unpleasant things that need to get done | 1 2 3 4 5 6 |
| 6. People should face their fears | 1 2 3 4 5 6 |
| 7. Happiness means never feeling any pain or disappointment | 1 2 3 4 5 6 |
| 8. I avoid activities if there is even a small possibility of getting hurt | 1 2 3 4 5 6 |
| 9. When negative thoughts come up, I try to fill my head with something else | 1 2 3 4 5 6 |
| 10. At times, people have told me I'm in denial | 1 2 3 4 5 6 |
| 11. I sometimes procrastinate to avoid facing challenges | 1 2 3 4 5 6 |
| 12. Even when I feel uncomfortable, I don't give up working toward things I value | 1 2 3 4 5 6 |
| 13. When I am hurting, I would do anything to feel better | 1 2 3 4 5 6 |
| 14. I rarely do something if there is a chance that it will upset me | 1 2 3 4 5 6 |
| 15. I usually try to distract myself when I feel something painful | 1 2 3 4 5 6 |
| 16. I am able to "turn off" my emotions when I don't want to feel | 1 2 3 4 5 6 |
| 17. When I have something important to do I find myself doing a lot of other things instead... | 1 2 3 4 5 6 |
| 18. I am willing to put up with pain and discomfort to get what I want | 1 2 3 4 5 6 |
| 19. Happiness involves getting rid of negative thoughts | 1 2 3 4 5 6 |
| 20. I work hard to avoid situations that might bring up unpleasant thoughts and feelings in me | 1 2 3 4 5 6 |
| 21. I don't realize I'm anxious until other people tell me | 1 2 3 4 5 6 |
| 22. When upsetting memories come up, I try to focus on other things | 1 2 3 4 5 6 |
| 23. I am in touch with my emotions | 1 2 3 4 5 6 |
| 24. I am willing to suffer for the things that matter to me | 1 2 3 4 5 6 |
| 25. One of my big goals is to be free from painful emotions | 1 2 3 4 5 6 |
| 26. I prefer to stick to what I am comfortable with, rather than try new activities | 1 2 3 4 5 6 |
| 27. I work hard to keep out upsetting feelings | 1 2 3 4 5 6 |
| 28. People have said that I don't own up to my problems | 1 2 3 4 5 6 |
| 29. Fear or anxiety won't stop me from doing something important | 1 2 3 4 5 6 |
| 30. I try to deal with problems right away | 1 2 3 4 5 6 |

1	2	3	4	5	6
strongly disagree	moderately disagree	slightly disagree	slightly agree	moderately agree	strongly agree

- 31. I'd do anything to feel less stressed 1 2 3 4 5 6
- 32. If I have any doubts about doing something, I just won't do it 1 2 3 4 5 6
- 33. When unpleasant memories come to me, I try to put them out of my mind 1 2 3 4 5 6
- 34. In this day and age people should not have to suffer 1 2 3 4 5 6
- 35. Others have told me that I suppress my feelings 1 2 3 4 5 6
- 36. I try to put off unpleasant tasks for as long as possible 1 2 3 4 5 6
- 37. When I am hurting, I still do what needs to be done 1 2 3 4 5 6
- 38. My life would be great if I never felt anxious 1 2 3 4 5 6
- 39. If I am starting to feel trapped, I leave the situation immediately 1 2 3 4 5 6
- 40. When a negative thought comes up, I immediately try to think of something else 1 2 3 4 5 6
- 41. It's hard for me to know what I'm feeling 1 2 3 4 5 6
- 42. I won't do something until I absolutely have to 1 2 3 4 5 6
- 43. I don't let pain and discomfort stop me from getting what I want 1 2 3 4 5 6
- 44. I would give up a lot not to feel bad 1 2 3 4 5 6
- 45. I go out of my way to avoid uncomfortable situations 1 2 3 4 5 6
- 46. I can numb my feelings when they are too intense 1 2 3 4 5 6
- 47. Why do today what you can put off until tomorrow 1 2 3 4 5 6
- 48. I am willing to put up with sadness to get what I want 1 2 3 4 5 6
- 49. Some people have told me that I "hide my head in the sand" 1 2 3 4 5 6
- 50. Pain always leads to suffering 1 2 3 4 5 6
- 51. If I am in a slightly uncomfortable situation, I try to leave right away 1 2 3 4 5 6
- 52. It takes me awhile to realize when I'm feeling bad 1 2 3 4 5 6
- 53. I continue working toward my goals even if I have doubts 1 2 3 4 5 6
- 54. I wish I could get rid of all of my negative emotions 1 2 3 4 5 6
- 55. I avoid situations if there is a chance that I'll feel nervous 1 2 3 4 5 6
- 56. I feel disconnected from my emotions 1 2 3 4 5 6
- 57. I don't let gloomy thoughts stop me from doing what I want 1 2 3 4 5 6
- 58. The key to a good life is never feeling any pain 1 2 3 4 5 6
- 59. I'm quick to leave any situation that makes me feel uneasy 1 2 3 4 5 6
- 60. People have told me that I'm not aware of my problems 1 2 3 4 5 6
- 61. I hope to live without any sadness and disappointment 1 2 3 4 5 6
- 62. When working on something important, I won't quit even if things get difficult 1 2 3 4 5 6

MULTIDIMENSIONAL EXPERIENTIAL AVOIDANCE QUESTIONNAIRE

- SCORING -

BEHAVIORAL AVOIDANCE
DISTRESS AVERSION
PROCRASTINATION
DISTRACTION & SUPPRESSION
REPRESSION & DENIAL
DISTRESS ENDURANCE

Total items 1, 8, 14, 20, 26, 32, 39, 45, 51, 55, 59
Total items 2, 7, 13, 19, 25, 31, 34, 38, 44, 50, 54, 58, 61
Total items 5, 11, 17, 30 (r), 36, 42, 47
Total items 3, 9, 15, 22, 27, 33, 40
Total items 4, 10, 16, 21, 23 (r), 28, 35, 41, 46, 49, 52, 56, 60
Total items 6, 12, 18, 24, 29, 37, 43, 48, 53, 57, 62

(r) indicates reverse-key item; to reverse-key, subtract item from " 7 "

TOTAL SCORE

Behavioral Avoidance + Distress Aversion + Procrastination +
Distraction & Suppression + Repression & Denial + (77 - Distress Endurance)

- NORMATIVE DATA -

COMMUNITY ADULTS
(N = 201)

COLLEGE STUDENTS
(N = 677)

PSYCHIATRIC PATIENTS
(N = 466)

	Mean	SD	+1.0	+1.5	Mean	SD	+1.0	+1.5	Mean	SD	+1.0	+1.5
BEHAV. AVOID	34.40	10.41	44.81	50.01	36.26	8.70	44.96	49.31	42.36	11.13	53.49	59.06
DISTRESS AVER.	41.65	11.97	53.62	59.60	43.24	11.46	54.70	60.43	50.47	12.63	63.10	69.42
PROCRASTINAT.	22.41	7.45	29.86	33.58	25.04	6.61	31.65	34.96	26.62	7.00	33.62	37.12
DIST./SUPPRESS.	25.64	6.58	32.22	35.51	26.02	6.35	32.37	35.55	28.79	7.55	36.34	40.12
REPRESS./DENIAL.	31.31	10.77	42.08	47.46	34.02	10.60	44.62	49.92	37.82	12.33	50.15	56.32
DISTRESS ENDUR.	47.12	7.93	39.19-	35.23-	46.51	7.66	38.85-	35.02-	43.21	9.57	33.64-	28.86-
TOTAL SCORE	185.29	39.95	225.24	245.21	195.08	34.46	229.54	246.77	224.61	39.94	264.55	284.52

Gamez, W., Chmielewski, M., Kotov, R., Ruggero, C., & Watson, D. (in press). Development of a measure of experiential avoidance: The Multidimensional Experiential Avoidance Questionnaire (MEAQ). *Psychological Assessment*.

Appendix L

Acceptance and Action Questionnaire-II

AAQ-II

Below you will find a list of statements. Please rate how true each statement is for you by circling a number next to it. Use the scale below to make your choice.

1	2	3	4	5	6	7						
never true	very seldom true	seldom true	sometimes true	frequently true	almost always true	always true						
1. My painful experiences and memories make it difficult for me to live a life that I would value.					1	2	3	4	5	6	7	
2. I'm afraid of my feelings.						1	2	3	4	5	6	7
3. I worry about not being able to control my worries and feelings.						1	2	3	4	5	6	7
4. My painful memories prevent me from having a fulfilling life.						1	2	3	4	5	6	7
5. Emotions cause problems in my life.						1	2	3	4	5	6	7
6. It seems like most people are handling their lives better than I am.						1	2	3	4	5	6	7
7. Worries get in the way of my success.						1	2	3	4	5	6	7

Appendix M

Composite Measure of Problem Behaviors

This questionnaire is designed to ask you about a range of behaviours that you may, or may not, engage in. It includes 46 statements and you are required to rate the extent to which each

statement characterises you, using the scale below
1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6

Very unlike me	Quite unlike me	A little unlike me	A little like me	Quite like me	Very Like me
-------------------	--------------------	-----------------------	---------------------	------------------	-----------------

For example, if you read a statement and think “it’s very unlike me to do X” you would write a “1” next to the statement. If you think “that’s only very slightly like me” write ‘4’, or if you think “it’s very like me to do that”, write ‘6’.

Before completing the questionnaire, please take note of the following points:

Where questions refer to internet use, this means non-work related use such as chat rooms, surfing the net etc. Where questions refer to sexual behaviours, this includes both foreplay and all forms of sexual intercourse. Where questions refer to drugs, this means the use of illegal drugs. This would include, for example, Cannabis, Cocaine, Ecstasy etc. Where questions refer to smoking, this means tobacco.

Please read each statement carefully and answer as honestly as possible. All answers are anonymous. Please do not leave any answers blank.

It's like me

1	to say no to drugs, including cannabis	1 2 3 4 5 6
2	to be pre-occupied by thoughts about smoking when smoking is prohibited	1 2 3 4 5 6
3	to sometimes consume more than 6 alcoholic drinks in one evening	1 2 3 4 5 6
4	to ignore dietary details (e.g., calorie content) when choosing something to eat	1 2 3 4 5 6
5	to exercise even when I am feeling tired and/or unwell	1 2 3 4 5 6
6	to sometimes intentionally prevent scars or wounds from healing	1 2 3 4 5 6
7	to smoke tobacco	1 2 3 4 5 6
8	to surf the net/play computer games before doing something else that needs doing	1 2 3 4 5 6
9	to generally have no interest in taking drugs, including cannabis	1 2 3 4 5 6
10	to sometimes engage in sexual activities with someone I have only just met.	1 2 3 4 5 6
11	to find that my work performance or productivity suffers because of my internet/video game use.	1 2 3 4 5 6
12	to never resort to violence.	1 2 3 4 5 6
13	to sometimes actively seek out drugs for personal use (this	1 2 3 4 5 6

	includes cannabis).	
14	to feel irritation/frustration if I am in a non-smoking environment.	1 2 3 4 5 6
15	to sometimes scratch or bite myself to the point of scarring or bleeding.	1 2 3 4 5 6
16	to sometimes feel pre-occupied with the internet/computer games.	1 2 3 4 5 6
17	to skip doing exercise for no good reason.	1 2 3 4 5 6
18	to drink a lot more alcohol than I initially intended.	1 2 3 4 5 6
19	to have a long list of things that I dare not eat.	1 2 3 4 5 6
20	to feel excitement and/or tension in anticipation of getting drunk.	1 2 3 4 5 6
21	to be content if I am prevented from exercising for a week.	1 2 3 4 5 6
22	to always stop eating when I feel full.	1 2 3 4 5 6
23	to prefer being in places where smoking is prohibited.	1 2 3 4 5 6
24	to control my temper.	1 2 3 4 5 6
25	to deliberately take small helpings as a means of controlling my weight.	1 2 3 4 5 6
26	to exercise more than three times a week.	1 2 3 4 5 6
27	to sometimes eat to the point of physical discomfort.	1 2 3 4 5 6

28	to sometimes feel tension and/or excitement in anticipation of doing exercise.	1 2 3 4 5 6
29	to sometimes cause myself direct bodily harm by, for example, cutting or burning myself.	1 2 3 4 5 6
30	to only eat when I am hungry.	1 2 3 4 5 6
31	to unsuccessfully try to cut back my use of the internet/computer games	1 2 3 4 5 6
32	to be excited by the opportunity of taking drugs (this includes cannabis)	1 2 3 4 5 6
33	to sometimes get so angry that I break something	1 2 3 4 5 6
34	to sometimes have more than one sexual partner.	1 2 3 4 5 6
35	to sometimes engage in sexual activities with someone when really I shouldn't	1 2 3 4 5 6
36	to easily limit my use of the internet or video games	1 2 3 4 5 6
37	to feel the urge to have a cigarette.	1 2 3 4 5 6
38	to sometimes feel that I need to take drugs (this includes cannabis)	1 2 3 4 5 6
39	to go out with friends who are drinking, but opt to stay sober	1 2 3 4 5 6
40	to sometimes think that I might have a drugs problem (this includes cannabis).	1 2 3 4 5 6

41	to avoid eating when I am hungry	1 2 3 4 5 6
42	to find it difficult to stop eating after certain foods	1 2 3 4 5 6
43	to be aggressive when sufficiently provoked	1 2 3 4 5 6
44	to feel the urge to intentionally harm myself	1 2 3 4 5 6
45	to sometimes feel that I need an alcoholic drink	1 2 3 4 5 6
46	to sometimes claim I have already eaten when this is not true	1 2 3 4 5 6

Appendix N

Life Events Checklist

LIFE EVENTS CHECKLIST

Listed below are a number of difficult or stressful things that sometimes happen to people. For each event check one or more of the boxes to the right to indicate that: (a) it happened to you personally, (b) you witnessed it happen to someone else, (c) you learned about it happening to someone close to you, (d) you're not sure if it fits, or (e) it doesn't apply to you.

Be sure to consider your entire life (growing up as well as adulthood) as you go through the list of events.

Event	Happened to me	Witnessed it	Learned about it	Not Sure	Doesn't apply
1. Natural disaster (for example, flood, hurricane, tornado, earthquake)					
2. Fire or explosion					
3. Transportation accident (for example, car accident, boat accident, train wreck, plane crash)					
4. Serious accident at work, home, or during recreational activity					
5. Exposure to toxic substance (for example, dangerous chemicals, radiation)					
6. Physical assault (for example, being attacked, hit, slapped, kicked, beaten up)					
7. Assault with a weapon (for example, being shot, stabbed, threatened with a knife, gun, bomb)					
8. Sexual assault (rape, attempted rape, made to perform any type of sexual act through force or threat of harm)					
9. Other unwanted or uncomfortable sexual experience					
10. Combat or exposure to a war-zone (in the military or as a civilian)					
11. Captivity (for example, being kidnapped, abducted, held hostage, prisoner of war)					
12. Life-threatening illness or injury					
13. Severe human suffering					
14. Sudden, violent death (for example, homicide, suicide)					
15. Sudden, unexpected death of someone close to you					
16. Serious injury, harm, or death you caused to someone else					
17. Any other very stressful event or experience					

18. For each event, please also indicate the number of times the event happened to you.

19. If you endorsed the experience of more than one life event, please specify which event caused you the most distress.

Appendix O

Posttraumatic Stress Disorder Checklist-Civilian

If you endorsed that you experienced a stressful life event in the previous questionnaire, please respond to the following questionnaire with the event that caused you the most distress in mind:

PCL-C

INSTRUCTIONS: Below is a list of problems and complaints that people sometimes have in response to stressful life experiences. Please read each one carefully, then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

	Not at all	A little bit	Moderately	Quite a bit	Extremely
1. Repeated, disturbing <i>memories, thoughts, or images</i> of a stressful experience from the past?	1	2	3	4	5
2. Repeated, disturbing <i>dreams</i> of a stressful experience from the past?	1	2	3	4	5
3. Suddenly <i>acting or feeling</i> as if a stressful experience <i>were happening again</i> (as if you were reliving it)?	1	2	3	4	5
4. Feeling <i>very upset</i> when <i>something reminded you</i> of a stressful experience from the past?	1	2	3	4	5
5. Having <i>physical reactions</i> (e.g., heart pounding, trouble breathing, sweating) when <i>something reminded you</i> of a stressful experience from the past?	1	2	3	4	5
6. Avoiding <i>thinking about or talking about</i> a stressful experience from the past or avoiding <i>having feelings</i> related to it?	1	2	3	4	5
7. Avoiding <i>activities or situations</i> because <i>they reminded you of</i> a stressful experience from the past?	1	2	3	4	5
8. Trouble <i>remembering important parts</i> of a stressful experience from the past?	1	2	3	4	5
9. <i>Loss of interest</i> in activities that you used to enjoy?	1	2	3	4	5
10. Feeling <i>distant or cut off</i> from other people?	1	2	3	4	5
11. Feeling <i>emotionally numb</i> or being unable to have loving feelings for those close to you?	1	2	3	4	5
12. Feeling as if your <i>future</i> will somehow be <i>cut short</i> ?	1	2	3	4	5
13. Trouble <i>falling or staying asleep</i> ?	1	2	3	4	5
14. Feeling <i>irritable</i> or having <i>angry outbursts</i> ?	1	2	3	4	5
15. Having <i>difficulty concentrating</i> ?	1	2	3	4	5
16. Being " <i>super-alert</i> " or watchful or on guard?	1	2	3	4	5
17. Feeling <i>jumpy</i> or easily startled?	1	2	3	4	5

Appendix P

College of Arts and Sciences Human Subjects Institutional Review Board Approval Letter

EASTERN MICHIGAN UNIVERSITY

Education First

September 30, 2013

Meaghan Lewis
Department of Psychology

Dear Meaghan:

The College of Arts and Sciences Human Subjects Review Committee (CAS HSRC) of Eastern Michigan University has reviewed and approved your proposal (#1203) "An Examination of Experiential Avoidance as a Vulnerability Factor for Posttraumatic Stress Symptoms and Excessive Behaviors in Parent and Adult Child Dyads." The CAS HSRC has determined that the rights and welfare of the individual subjects involved in this research are carefully guarded. Additionally, the methods used to obtain informed consent are appropriate, and the individuals participating in your study are not at risk.

You are reminded of your obligation to advise the HSRC of any change in the protocol that might alter your research in any manner that differs from that upon which this approval is based. Approval of this project applies for one year from the date of this letter. If your data collection continues beyond the one-year period, you must apply for a renewal. Please specify in your consent form that approval is from 9/30/13 to 9/29/14.

On behalf of the Human Subjects Committee, I wish you success in conducting your research.

Sincerely,



Alissa Huth-Bocks, Ph.D.
CAS Human Subjects Review Committee Chair

Note: If project continues beyond the length of **one** year, please submit a continuation request form by 9/29/2014.

cc: Tamara Loverich, Ph.D.

EASTERN MICHIGAN UNIVERSITY
Graduate School
ORAL DEFENSE of the MASTER'S THESIS
Approval Form

Student Name Meaghan M. Lewis

Program of Study Clinical Behavioral Master's ID# E 01126880

TITLE OF THESIS

"An Examination of Experiential Avoidance as a Vulnerability Factor for Posttraumatic Stress Symptoms and Excessive Behaviors in Parent and Young Adult Child Dyads"

ORAL DEFENSE

Date July 15, 2014 Time 1:00 pm Place Mark Jefferson Science Complex

After review of the thesis and on the basis of the oral defense of the work presented in the thesis, the master's committee certifies that the candidate:

- Satisfactorily passed the oral defense of the thesis
 Did not satisfactorily pass the oral defense of the thesis

Recommendations _____

COMMITTEE SIGNATURES

FINAL document approval of the written requirement will occur upon review of suggested edits with signatures on the *THESIS DOCUMENT APPROVAL FORM*.

Chair: 
Tamara M. Loverich, Ph.D.

Members: 
Ellen Koch, Ph.D.


Flora Hoodin, Ph.D.

ACKNOWLEDGEMENT OF PASSING THE ORAL DEFENSE

Date 7-15-14 
Director of Clinical Training/Master's Program Coordinator/Department Head

Signed original to department file

THESIS INFORMATION SHEET

NAME Meaghan M. Lewis STUDENT # E01126880

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Dept/School Psychology Committee Chair Tamara M. Loverich, Ph.D.

Title of Thesis "An Examination of Experiential Avoidance as a Vulnerability Factor for Posttraumatic
Stress Symptoms and Excessive Behaviors in Parent and Young Adult Child Dyads"

Signature _____

Style Guide Used (check one):

____ ACS APA ____ MLA ____ AIP ____ ASA ____ AMA ____ CBE
____ Chicago ____ Turabian

For office use only--Graduate School staff must complete the following:

Is Approval Form signed by all committee members and the department head/school director?

____ Yes ____ No

If the research involved the use of human or animal subjects, is evidence of approval from the HSRC or IACUC submitted with the thesis? ____ Yes ____ No

1. If the answers to both the above questions are "yes," you may accept the thesis from the student. If not, return it to the student for compliance with the above requirements.
2. Date stamp below. Name of staff person accepting thesis _____
3. Make two copies of this form. One copy goes to student and the other to the reader. **DATE STAMP HERE**
4. Enter in database and Banner and file original in binder.

Figure 12. Thesis information sheet.

