



Psychological Inflexibility: The Role of Trans Diagnostic Processes in Major Depressive Disorder, Generalized Anxiety Disorder and Obsessive-Compulsive Disorder

Mohammadreza Norouzi ¹, Fatemeh Nazari ¹, Javad Karimi ², Tohid Ranjbari ³, Shahab Lotfinia ¹, Banafsheh Mohajerin ^{4,*}

¹ Department of Clinical Psychology, School of Medicine, Shahid Beheshti University of Medical Sciences, Tehran, Iran

² Department of Psychology, School of literature and Humanity Sciences, The University of Malayer, Malayer, Iran

³ Tehran University, Tehran, Iran

⁴ Taleghani Hospital Research Developmental Unit, School of Medicine, Shahid Beheshti University of Medical Sciences, Tehran, Iran

*Corresponding Author: Taleghani Hospital Research Developmental Unit, School of Medicine, Shahid Beheshti University of Medical Sciences, Tehran, Iran. Email: banafshehmohajerin@gmail.com

Received: 29 June, 2024; Accepted: 12 June, 2024

Abstract

Background: The high rate of coexistence between emotional disorders has prompted researchers to look for extradiagnostic factors that are involved in the formation and persistence of most mental disorders. One of these overdiagnostic factors is psychological flexibility, which has been considered as a factor in the development of most mental disorders in recent years.

Objectives: The present study was conducted with the aim of comparing the components of the psychological flexibility model in patients with major depressive disorder (MDD), generalized anxiety disorder (GAD), and obsessive-compulsive disorder (OCD) with normal individuals.

Methods: In a causal-comparative research design, 20 patients with GAD, 20 patients with OCD, 20 patients with MDD were compared with 20 normal people (control group). Sick and normal people were selected through available sampling from among the people referring to the psychiatric clinics of Malayer city and normal people living in Malayer respectively. To determine the difference between the patient group and the control group, multivariate analysis of variance (MANOVA) was performed.

Results: Patients with GAD, OCD, and MDD had higher experiential avoidance, higher cognitive integration, and lower mind-awareness and value-oriented life compared to the control group. However, there was no significant difference in dependent variables between the three groups of GAD, OCD and MDD patients.

Conclusions: Considering the significant difference between patients with emotional disorders and the control group in terms of psychological flexibility, interventions that help to increase psychological flexibility can be used to treat this group of patients.

Keywords: Psychological Flexibility, Emotional Disorders, Cognitive Fusion, Experiential Avoidance

1. Background

Comorbidity is often found among mental disorders, suggesting that these disorders may share common pathological processes (1). Therefore, in clinical psychology, there is a great emphasis on creating transdiagnostic models and interventions for a wide range of disorders. In this regard, we can refer to the underlying theory of acceptance and commitment

therapy (ACT) (2). Acceptance and commitment therapy is one of the third generation cognitive behavioral therapies based on the transdiagnostic approach and states that human suffering is due to psychological inflexibility and experiential avoidance (3). Psychological inflexibility is defined based on six main processes: Experiential avoidance, cognitive fusion, contact with the past or future, self as content, unclear personal values and lack of committed behaviors (4).

Many studies with adult samples have shown that psychological inflexibility is strongly associated with emotional distress, psychopathology, and poor quality of life (5, 6). In this regard, a growing body of research suggests associations between psychological inflexibility (PI) and various psychological problems, including symptoms of depression, anxiety, and stress during the COVID-19 pandemic (7, 8). Major depressive disorder is one of the most common mental disorders in the world, which affects more than 264 million people worldwide and is known as the most common disorder in general population (9). In a study conducted in Iran to investigate the prevalence of major depressive disorder, it has been shown that the overall prevalence of major depressive disorder is 4.8% in women and 2.3% in men (10). Among all psychiatric disorders, comorbidity is a rule, which is certainly true about the anxiety and depressive disorders as well as their symptoms. In this regard, the results of a worldwide survey indicate that 45.7% of people with major depressive disorder had a lifetime history of one or more anxiety disorders. Generalized anxiety disorder (GAD) can be mentioned among anxiety disorders (11). Research on twins suggests that there is a common genetic basis for anxiety disorders and some forms of obsessive-compulsive disorder (OCD), but also suggests that obsessive-compulsive symptoms may be a risk factor for developing some anxiety disorders, such as GAD. The OCD is a chronic neuropsychiatric disorder that is seen in about 2 - 3% of the general population (12) and is currently the fourth most common mental disorder after depression, alcohol/drug abuse and social phobia (13). According to a recent epidemiological study in Iran, the annual prevalence of this disorder is estimated about 1.5% (14). Considering the high prevalence of emotional disorders, understanding the etiological factors of these disorders has become very important.

2. Objectives

Therefore, considering this information, examining psychological inflexibility can be helpful in understanding and subsequently treating psychological distress in different populations. In terms of supposed risk factors, it may be especially important to identify and offer primary prevention to those individuals who are high in both cognitive fusion and EA.

3. Methods

3.1. Participants and Procedure

The present study is a comparative causal study. The statistical population of this research is all the patients diagnosed with generalized anxiety disorder, obsessive-compulsive disorder, major depressive disorder and the normal people of the Malayer city at the Hamedan province. G*Power software was used to determine the sample size. Based on this software and considering $\alpha = 0.05$ and power = 0.80, the calculated sample size for each group is 20 people (20 patients with generalized anxiety disorder, 20 patients with obsessive-compulsive disorder, 20 patients with major depressive disorder and 20 normal people) who were selected from the clients of a private psychiatric clinic in Malayer by convenience sampling method. Among the clients of this clinic, if a person received one of the diagnoses of major depressive disorder, generalized anxiety disorder and obsessive compulsive disorder by a psychiatrist, they would be referred to the researcher. Then a structured clinical interview was conducted and if they had the other inclusion criteria, they would receive the informed consent form and the other questionnaires. It should be noted that the control group of this study was also selected among the companions of the patients. If the psychiatrist determined that they are without an obvious psychiatric disorder, they were selected as the control group. The inclusion criteria of the patient groups were having a diagnosis of MDD, GAD and OCD, having at least a diploma to understand the items of questionnaires and the absence of any comorbid psychological disorders. Also the individuals in normal group must had at least a diploma degree to understand the questions of the questionnaires and did not have any diagnosed psychiatric disorder. Furthermore, the participants who did not fill the questionnaires completely were excluded. Finally, the collected data were analyzed through multivariate analysis of variance to determine the difference between groups.

3.2. Measures

3.2.1. Acceptance and Action Questionnaire (AAQ-II)

This questionnaire was developed by Bund et al. (15) in 2007 in order to evaluate the experiential avoidance and psychological flexibility (16). The latest version has 10 questions that are scored on a 7-point Likert scale (17). Higher scores indicate greater experiential avoidance and less psychological flexibility (18). Therefore, total scores above 24 - 28 may indicate a level of distress which is clinically significant. Also, the average Cronbach's alpha coefficient for different clinical and non-clinical groups was reported as 0.84 and for the Persian version between 0.71 and 0.89 (19).

3.2.2. Engaged Living Scale

The Engaged Living Scale (ELS) was designed by Trumpter et al. in 2013. The items of this questionnaire are rated on a 5-point Likert scale (strongly disagree = 1, disagree = 2, have no opinion = 3, agree = 4, strongly agree = 5). Internal reliability is reported as 0.86 (trumpter). In this research, Cronbach's alpha coefficient of this questionnaire was 0.882.

3.2.3. Five Facet Mindfulness Questionnaire

The most comprehensive and widely used conceptualization of aspects of mindfulness is obtained from the five-facet mindfulness questionnaire. The Five Facet Mindfulness Questionnaire (FFMQ) was obtained through factor analysis of items from five different mindfulness questionnaires and thus represents an empirical integration based on different conceptualizations of mindfulness. Aspects of the FFMQ include the desire to observe internal and external experiences (observing), describing internal experiences with words (describing), acting with awareness of the present (acting with awareness), adopting a non-judgmental stance towards internal experiences (non-judgmental) and allowing one's thoughts and feelings to come without focusing or explaining them further (non-reaction) (19).

3.2.4. Cognitive Fusion Questionnaire (CFQ)

This questionnaire was developed by Gillanders et al. in 2014 (as cited in Bardeen and Fergus) to measure cognitive fusion and has 7 items (19, 20) which are rated on a 7-point Likert scale (never = 1, very rarely = 2, rarely = 3, sometimes = 4, most of the time = 5, almost always = 6, always = 7). Higher scores on this scale indicate lower psychological flexibility and higher cognitive fusion (20). The test-retest reliability and the internal consistency of this questionnaire were 0.86 and 0.91 respectively (21). In present study, the Cronbach's alpha coefficient was calculated as 0.872.

4. Results

Demographic characteristics of the sample presented in Tables 1 and 2. Multivariate analysis of variance (MANOVA) was used to compare the scores of experiential avoidance, mindfulness, cognitive fusion and value oriented life among groups. Before using the parametric test of MANOVA, Box's M and Levene's tests were used to check its assumptions. Based on the Box's M test, which was not significant for any of the variables, the assumption of homogeneity of the

variance/covariance matrix was met ($P = 0.52$, $F = 0.98$, $BOX = 72.10$). Also, considering that the Levene's test results were not significant for any of variables it can be concluded that the assumption of homogeneity of inter-group variances is confirmed in present study.

Table 3 shows that there is a significant difference between the participants of studied groups (obsessive compulsive disorder, major depressive disorder, generalized anxiety disorder and the normal one) in the dependent variables of experiential avoidance, mindfulness, cognitive fusion and value-oriented life. Furthermore, Tukey's follow-up test was used to evaluate the differences among groups. The results show that there is a significant difference in dependent variables between the groups of OCD, MDD, GAD and the normal one. However, there is no significant difference in the dependent variables among the three groups of OCD, MDD and GAD.

Furthermore, according to the significance tests of the multivariate analysis of variance, including Pillai's effect, Wickels' lambda, the group's Hotelling effect and the Roy's Largest Root, the main effect of group variable on the dependent variables is statistically significant at the significance level of 0.001 (Table 4).

5. Discussion

The present study was conducted with the aim of investigating the role of the transdiagnostic factor of psychological flexibility (including experiential avoidance, mindfulness, cognitive fusion and value-oriented life) in major depressive disorder, generalized anxiety disorder and obsessive-compulsive disorder. The results of this study generally showed that the patients with major depressive disorder, generalized anxiety disorder and obsessive-compulsive disorder have less psychological flexibility than the control group, but the observed differences among these three patient groups were not statistically significant.

Our findings demonstrated that the patients with OCD have more psychological inflexibility (more experiential avoidance, more cognitive fusion and less mindfulness). Experiential avoidance is conceptualized as a tendency to avoid, escape or alter one's experience of unpleasant internal events (such as thoughts, feelings, memories and emotions). In this regard, it can be said that the experiential avoidance plays an essential role in the pathology of obsessive-compulsive disorder. In fact, symptoms of obsessive-compulsive disorder include: (A) Unwanted thoughts, images, and impulses that cause anxiety (eg, images of germs, thoughts of transgression); and (B) mental behaviors or actions (neutralizing and compulsive rituals such as hand

Table 1. The Sample Demographic Characteristics

Variables	GAD	OCD	MDD	Control
Age (mean)	27.25	27.35	26.35	27.75
Gender (%)	60	45	65	35
Education (%)				
Diploma	40	50	30	40
Bachelor	25	20	40	35
Master	20	30	25	10
Ph.D	15	0	5	15

Abbreviations: GAD, generalized anxiety disorder; OCD, obsessive-compulsive disorder; MDD, major depressive disorder.

Table 2. Mean and Standard Deviation of Experiential Avoidance, Mindfulness, Cognitive Fusion and Value-Oriented Life in Research Groups (n=20)^a

Variables	Experiential Avoidance	Mindfulness	Cognitive Fusion	Value-Oriented Life
OCD	32.68 ± 9.46	69.76 ± 14.27	36.57 ± 8.72	53.67 ± 11.83
MDD	33.05 ± 8.12	66.86 ± 6.70	38.40 ± 9.22	48.35 ± 10.91
GAD	30.91 ± 9.22	68.81 ± 9.76	38.46 ± 7.03	50.13 ± 9.86
Normal	20.10 ± 9.79	79.37 ± 13.02	26.45 ± 10.86	64.12 ± 7.67

Abbreviations: GAD, generalized anxiety disorder; OCD, obsessive-compulsive disorder; MDD, major depressive disorder.

^aValues are expressed as mean ± SD.

Table 3. Results of Multivariate Variance Analysis of Group Effects on Dependent Variables

Dependent Variables	Sum of Squares	df	Mean Square	F	Level of Significance
Experiential avoidance	2553.87	3	751.29	8.92	0.001
Mindfulness	1668.82	3	622.94	4.84	0.004
Cognitive fusion	1982.32	3	660.77	8.00	0.001
Value-oriented life	2989.64	3	996.54	9.59	0.001

washing, reassurance seeking, and thought suppression) in order to resist the obsession and reduce the anxiety caused by it (22). According to this definition, it can be claimed that experiential avoidance is one of the main characteristics of OCD because it requires resistance and escape from disturbing private experiences which is the same as unwanted obsessions in OCD (22).

In explaining the psychological inflexibility of patients diagnosed with GAD, we can refer to Borkovec *et al.* who proposed that the worry, as the main characteristic of GAD, has an avoidant role which leads to the continuation of disorder (23, 24). Furthermore, the world in which humans live endorses the suppression of emotions and the bilaterality of the language enables the human to categorize the various situations as aversive or “bad”, which can be applied about the internal experiences. Considering that if

anxiety is labeled as a bad experience, then it can be annoying to even think about it. So individuals can learn to avoid these thoughts in an effort to remove such bad experience (25, 26).

Furthermore our findings demonstrated that the patients diagnosed with MDD have also less psychological flexibility. Our results have been approved in other studies too. In this regard, we can refer to the results of Rueda and Valls's study, according to which a strong and positive correlation was reported between depressive symptoms with experiential avoidance and stressful life events (27, 28). Cookson *et al.* also obtained similar results. The results indicated that the reciprocal relationship between experiential avoidance and cognitive fusion explains a considerable part of the correlation between rumination and depression and stressful life events (28). Evidences suggest that a ruminative style in responding clearly contributes to the

Table 4. Results of Multivariate Variance Analysis of Group Effects on Dependent Variables

Test	Value	F	Level of Significance	Power
Pillai's effect	0.4	2.94	0.001	0.98
Wickels'lambda	0.61	3.27	0.001	0.98
Hotelling effect	0.59	3.57	0.001	0.99
Roy's Largest Root	0.53	10.08	0.001	1

persistence of MDD and is also considered as a susceptibility to the disorder. A paradoxical idea is that rumination is actually a manifestation of experiential avoidance. Similarly to the role of worry in Borkovec's model, depressive rumination enables individuals to avoid experiencing the sadness but at the same time give a false impression that they are actually (29).

5.1. Limitation

The current study highlights the role of the psychological inflexibility as a transdiagnostic variable among MDD, OCD, GAD and normal people which provides some theoretical basis for the intervention of ACT. However, the interpretation of the findings of any study should be considered with adequate caution due to its limitations. For example, due to existing limitations, it was not possible to choose participants randomly and the convenience sampling method was inevitably used. Therefore, future studies will provide more valuable information by selecting the sample randomly. Moreover, this study only includes four aspects: Cognitive fusion, experiential avoidance, mindfulness and value oriented life in ACT pathological model. However, the ACT pathological model includes six aspects and the generalization of self and ineffective action are not discussed in this study.

Footnotes

Authors' Contribution: B. M and M. N. conceived and designed the evaluation and drafted the manuscript. F. N., Sh. L., J. K., and T. R. contributed to the evaluation design, performed portions of the statistical analysis, and assisted in drafting the manuscript. B. M., F. N., Sh. L., J. K., and M. N. reviewed and revised the clinical data and manuscript and performed the additional statistical analysis. F. N., Sh. L., J. K., and T. R. collected and interpreted the clinical data and revised the manuscript. B. M. and M. N. reanalyzed the clinical and statistical data and revised the manuscript. All authors have reviewed and approved the final manuscript.

Conflict of Interests Statement: The authors declare no conflicts of interest, whether actual or potential, including any financial, personal, or other relationships with individuals or organizations that could inappropriately influence the submitted work outcomes.

Data Availability: The dataset utilized in the study can be obtained upon request from the corresponding author during submission or following publication. The data is not publicly accessible due to privacy and ethical considerations.

Ethical Approval: This study is approved under the ethical approval code of [IR.SBMU.RETECH.REC.1402.057](#).

Funding/Support: This study was supported by the School of Medicine, Shahid Beheshti University of Medical Sciences (grant No. 33293).

Informed Consent: Written informed consent was obtained from all participants.

References

1. Kessler RC, Berglund P, Demler O, Jin R, Merikangas KR, Walters EE. Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. *Arch Gen Psychiatry*. 2005;62(6):593-602. [PubMed ID: 15939837]. <https://doi.org/10.1001/archpsyc.62.6.593>.
2. Mansell W, Harvey A, Watkins E, Shafran R. Conceptual Foundations of the Transdiagnostic Approach to CBT. *J Cognitive Psycho*. 2009;23(1):6-19. <https://doi.org/10.1891/0889-8391.23.1.6>.
3. Hayes SC, Pistorello J, Levin ME. Acceptance and Commitment Therapy as a Unified Model of Behavior Change. *The Counsel Psychol*. 2012;40(7):976-1002. <https://doi.org/10.1177/0011000012460836>.
4. Finger IDR, de Freitas BI, Oliveira MDS. Psychological inflexibility in overweight and obese people from the perspective of acceptance and commitment therapy (ACT). *Eat Weight Disord*. 2020;25(1):169-75. [PubMed ID: 30019259]. <https://doi.org/10.1007/s40519-018-0541-y>.
5. Hernandez-Lopez M, Cepeda-Benito A, Diaz-Pavon P, Rodriguez-Valverde M. Psychological inflexibility and mental health symptoms during the COVID-19 lockdown in Spain: A longitudinal study. *J Contextual Behav Sci*. 2021;19:42-9. [PubMed ID: 33520642]. [PubMed Central ID: PMC7834284]. <https://doi.org/10.1016/j.jcbs.2020.12.002>.
6. Landi G, Pakenham KI, Crocetti E, Tossani E, Grandi S. The trajectories of anxiety and depression during the COVID-19 pandemic and the protective role of psychological flexibility: A four-wave longitudinal

study. *J Affect Disord.* 2022;307:69-78. [PubMed ID: 35378147]. [PubMed Central ID: PMC8972980]. <https://doi.org/10.1016/j.jad.2022.03.067>.

7. Bonilla-Sierra P, Manrique GA, Hidalgo-Andrade P, Ruisoto P. Psychological Inflexibility and Loneliness Mediate the Impact of Stress on Anxiety and Depression Symptoms in Healthcare Students and Early-Career Professionals During COVID-19. *Front Psychol.* 2021;12:729171. [PubMed ID: 34621223]. [PubMed Central ID: PMC8491304]. <https://doi.org/10.3389/fpsyg.2021.729171>.
8. Amiri S. Unemployment associated with major depression disorder and depressive symptoms: a systematic review and meta-analysis. *Int J Occup Saf Ergon.* 2022;28(4):2080-92. [PubMed ID: 34259616]. <https://doi.org/10.1080/10803548.2021.1954793>.
9. Ruisoto P, Lopez-Guerra VM, Lopez-Nunez C, Sanchez-Puertas R, Paladines-Costa MB, Pineda-Cabrera NJ. Transdiagnostic model of psychological factors and sex differences in depression in a large sample of Ecuador. *Int J Clin Health Psychol.* 2022;22(3):100322. [PubMed ID: 35892040]. [PubMed Central ID: PMC9305621]. <https://doi.org/10.1016/j.ijchp.2022.100322>.
10. Kessler RC, Sampson NA, Berglund P, Gruber MJ, Al-Hamzawi A, Andrade L, et al. Anxious and non-anxious major depressive disorder in the World Health Organization World Mental Health Surveys. *Epidemiol Psychiatr Sci.* 2015;24(3):210-26. [PubMed ID: 25720357]. [PubMed Central ID: PMC5129607]. <https://doi.org/10.1017/S2045796015000189>.
11. Vicheva P, Butler M, Shotbolt P. Deep brain stimulation for obsessive-compulsive disorder: A systematic review of randomised controlled trials. *Neurosci Biobehav Rev.* 2020;109:129-38. [PubMed ID: 31923474]. <https://doi.org/10.1016/j.neubiorev.2020.01.007>.
12. Eskander N, Limbana T, Khan F. Psychiatric Comorbidities and the Risk of Suicide in Obsessive-Compulsive and Body Dysmorphic Disorder. *Cureus.* 2020. <https://doi.org/10.7759/cureus.9805>.
13. Orooji M, Khosravi S, Malekpour F, Shalbafan M. Late-Onset Obsessive-Compulsive Disorder Secondary to Caudate Lacunar Infarct: A Case Report. *Case Rep Clin Pract.* 2018;3(2):53-6.
14. Abramowitz JS, Lackey GR, Wheaton MG. Obsessive-compulsive symptoms: the contribution of obsessional beliefs and experiential avoidance. *J Anxiety Disord.* 2009;23(2):160-6. [PubMed ID: 18657382]. <https://doi.org/10.1016/j.janxdis.2008.06.003>.
15. Bassak Nejad S, Yunesi A, Sadatmand K. [The relationship between anxiety sensitivity and experiential avoidance and resiliency with test anxiety in male students]. *J Clin Psychol.* 2018;10(1):71-8. FA. <https://doi.org/10.22075/jcp.2018.13974.1361>.
16. Moradi Kelardeh S, Aghajani S, Ghasemi Jobaneh R, Baharvand I. [Role of Integrative Self-knowledge, Experiential Avoidance and Self-Compassion in Test Anxiety of female Students]. *Educ Strategy Med Sci.* 2019;12(1):110-5. FA. <https://doi.org/10.29252/edcbmj.12.01.15>.
17. Reuman L, Buchholz J, Abramowitz JS. Obsessive beliefs, experiential avoidance, and cognitive fusion as predictors of obsessive-compulsive disorder symptom dimensions. *Journal of Contextual Behavioral Science.* 2018;9:15-20. <https://doi.org/10.1016/j.jcbs.2018.06.001>.
18. Abasi E, Fti L, Molodi R, Zarabi H. [Psychometric properties of Persian version of acceptance and action questionnaire-II]. *Psychol Models Methods.* 2012;3(10/Winter 2013):65-80. FA.
19. Carpenter JK, Conroy K, Gomez AF, Curren LC, Hofmann SG. The relationship between trait mindfulness and affective symptoms: A meta-analysis of the Five Facet Mindfulness Questionnaire (FFMQ). *Clin Psychol Rev.* 2019;74:101785. [PubMed ID: 31751877]. [PubMed Central ID: PMC6878205]. <https://doi.org/10.1016/j.cpr.2019.101785>.
20. Bardeen JR, Fergus TA. The interactive effect of cognitive fusion and experiential avoidance on anxiety, depression, stress and posttraumatic stress symptoms. *Journal of Contextual Behavioral Science.* 2016;5(1):1-6. <https://doi.org/10.1016/j.jcbs.2016.02.002>.
21. Eifert GH, Forsyth JP. *Acceptance & Commitment Therapy for anxiety disorders: A practitioner's treatment guide to using mindfulness, acceptance, and values-based behavior change strategies.* New Harbinger Publications; 2005.
22. Xiong A, Lai X, Wu S, Yuan X, Tang J, Chen J, et al. Relationship Between Cognitive Fusion, Experiential Avoidance, and Obsessive-Compulsive Symptoms in Patients With Obsessive-Compulsive Disorder. *Front Psychol.* 2021;12:655154. [PubMed ID: 3391217]. [PubMed Central ID: PMC8072044]. <https://doi.org/10.3389/fpsyg.2021.655154>.
23. Borkovec TD. *Avoidance theory of worry and generalized anxiety disorder.* New York: Guilford Press; 2004. p. 77-108.
24. Hayes SC, Wilson KG, Gifford EV, Follette VM, Strosahl K. Experimental avoidance and behavioral disorders: a functional dimensional approach to diagnosis and treatment. *J Consult Clin Psychol.* 1996;64(6):1152-68. [PubMed ID: 8991302]. <https://doi.org/10.1037/0022-006X.64.6.1152>.
25. Hayes SC, Luoma JB, Bond FW, Masuda A, Lillis J. Acceptance and commitment therapy: model, processes and outcomes. *Behav Res Ther.* 2006;44(1):1-25. [PubMed ID: 16300724]. <https://doi.org/10.1016/j.brat.2005.06.006>.
26. Lee JK, Orsillo SM. Investigating cognitive flexibility as a potential mechanism of mindfulness in Generalized Anxiety Disorder. *J Behav Ther Exp Psychiatry.* 2014;45(1):208-16. [PubMed ID: 24239587]. <https://doi.org/10.1016/j.jbtep.2013.10.008>.
27. Rueda B, Valls E. Relationships among Stress, Experiential Avoidance and Depression in Psychiatric Patients. *Span J Psychol.* 2016;19. E27. [PubMed ID: 27210826]. <https://doi.org/10.1017/sjp.2016.32>.
28. Cookson C, Luzon O, Newland J, Kingston J. Examining the role of cognitive fusion and experiential avoidance in predicting anxiety and depression. *Psychol Psychother.* 2020;93(3):456-73. [PubMed ID: 30994261]. <https://doi.org/10.1111/papt.12233>.
29. Thomas J, Raynor M, Ribott D. Depressive rumination and experiential avoidance: a task based exploration. *Personal Ment Health.* 2015;9(1):58-65. [PubMed ID: 25273612]. <https://doi.org/10.1002/pmh.1276>.