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The Role of Experiential Avoidance in the Relation between Anxiety Disorder Diagnoses and Future Physical Health Symptoms in a Community Sample of Young Adult Women☆

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Abstract

Individuals diagnosed with an anxiety disorder report more physical health problems than those without an anxiety disorder. Few studies have examined the relation of anxiety disorders to later physical health symptoms, or the processes that may explain this relation. One process of interest is experiential avoidance (EA), which is commonly reported in populations characterized by high anxiety and often leads to health-compromising behaviors. The present study examined the relations between anxiety disorder diagnostic status, EA, and physical health symptoms in a community sample of young adult women. Results revealed a significant association between an anxiety disorder diagnosis and physical health problems four months later. Furthermore, levels of EA accounted for this relation. Findings highlight the potential utility of targeting EA as a method for improving health outcomes among individuals with anxiety disorders.

Keywords

Anxiety Disorders; Physical Health Symptoms; Experiential Avoidance

Anxiety disorders are the most prevalent mental health problem in the United States (Kessler et al., 2005), and disproportionally affect women (McLean, Asnaani, Litz, & Hofmann, 2011). Often beginning at an early age (Kessler et al., 2005), anxiety disorders are associated with considerable disability and impairment across occupational, relationship, and physical health domains (Kariuki-Nyuthe & Stein, 2015; McLean et al., 2011; Roy-Byrne et al., 2008). With regard to the latter, the physical health problems experienced by individuals

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with anxiety disorders include obesity, diabetes, allergies, cancer, cataracts, thyroid problems, pain-related conditions, psoriasis, and cardiovascular, heart, gastrointestinal, and respiratory diseases (El-Gabalawy, Mackenzie, Shooshtari, & Sareen, 2011; Gili et al., 2010; Niles et al., 2015; Roy-Byrne et al., 2008; Sanna et al., 2013; Sareen et al., 2006; Scott et al., 2007). Anxiety disorders are also associated with high medical burden (defined as three or more medical diagnoses; Sanna et al., 2013) and multiple indices of health-related disability. For example, individuals with anxiety disorders report heightened intensity of physical health symptoms (Oh, Cho, Chung, Kim, & Chu, 2014), increased difficulty carrying out daily activities (Kessler, Ormel, Demler, & Stang, 2003; McCauley, Katon, Russo, Richardson, & Lozano, 2007; Merikangas et al., 2007; Sareen et al., 2006), and poor general physical health (El-Gabalawy et al., 2011). Research also indicates a synergistic effect of anxiety disorders and physical illness on physical disability, with the combination resulting in greater disability than the additive effect of each problem individually (Scott et al., 2009).

It is this disability that likely contributes to increased health care utilization by individuals with anxiety disorders. For example, anxiety disorders are related to more frequent use of primary care services, including non-psychotropic medications, emergency department visits, inpatient admissions, and costly medical tests and procedures (Feldman et al., 2005; Simpson, Kazmierczak, Power, & Sharp, 1994; Zaubler & Katon, 1998). The occurrence of physical health symptoms among individuals with an anxiety diagnosis results in considerable strain on the medical health system and represents a significant public health burden.

Despite the importance of research in this area, few studies have examined the prospective effects of anxiety disorders in young adulthood on general physical health symptoms. Moreover, although preliminary evidence indicates that the presence (vs. absence) of an anxiety diagnosis in adolescence is associated with more self-reported pain, physical illness, and poor physical health up to 20 years later (Chen et al., 2009), no studies have examined the behavioral processes that may account for poor physical health among individuals with anxiety disorders. Thus, the precise nature and strength of the relation of anxiety disorders to future physical health problems remains unclear. In particular, it is possible that anxiety disorders are a proxy risk factor for some key behavioral process or mechanism that relates to physical health problems (see Kraemer, Stice, Kazdin, Offord, Kupfer, 2001). A proxy risk factor model is considered applicable when the temporal precedence of two correlated putative risk factors for some outcome is not clear, and when one risk factor (i.e., the proxy risk factor) is only (or primarily) related to an outcome due to their shared association with a stronger, or more dominant, global risk factor for that outcome. Identification of global risk factors for physical health problems would facilitate the development of more efficient and targeted interventions aimed at improving the health of populations with elevated anxiety (Kraemer et al., 2001).

One process that warrants examination in this regard is experiential avoidance (EA), defined as rigid behavioral attempts to alter the form, frequency, or intensity of unwanted private events (i.e., thoughts, emotions, and physical sensations) when such behavior impedes valued living (Hayes et al., 2004; Hayes, Strosahl, & Wilson, 2012). Evidence suggests that self-reported EA is strongly linked to both anxiety (e.g., Kashdan, Zvolensky, & McLeish,

2008; Tull & Roemer, 2008) and specific anxiety-related disorders, including posttraumatic stress disorder (Kashdan, Morina, & Priebe, 2009; Valdez & Lilly, 2012), social anxiety disorder (Kashdan, Breen, Afram, & Terhar, 2010; Kashdan et al., 2009), and generalized anxiety disorder (Roemer, Salters, Raffa, & Orsillo, 2005). Moreover, behavioral expressions of EA in the context of anxiety disorders (such as emotional and thought suppression and risky behaviors) are associated with negative health consequences. For example, the suppression of thoughts and emotions (an avoidance-oriented strategy common among people with anxiety; Campbell-Sills, Barlow, Brown, & Hofmann, 2006a; Levitt, Brown, Orsillo, & Barlow, 2004) has been found to increase subjective distress and physiological dysregulation (e.g., Campbell-Sills, Barlow, Brown, & Hofmann, 2006b; Gillanders, Wild, Deighan, & Gillanders, 2008; Gross & Levenson, 1997; Marcks & Woods, 2005; Wegner, Shortt, Blake, & Page, 1990) – the latter of which predicts poor future physical health (Milot et al., 2014). EA is also linked to a variety of risky behaviors (e.g., substance use: Stewart, Zvolensky, & Eifert, 2002; risky sexual behaviors: Batten, Follette, & Aban, 2002) that may, themselves, have negative health consequences. Taken together, and consistent with evidence that EA operates as a general psychological vulnerability factor (Kashdan, Barrios, Forsyth, & Steger, 2006), this body of research suggests that EA may be a global risk factor for physical health problems among individuals with anxiety disorders, with the presence of an anxiety disorder diagnosis serving as a proxy for EA in the risk for later physical health symptoms.

Based on the above theory and research, we tested a proxy risk factor model of the interrelations of anxiety disorder diagnosis, EA, and physical health symptoms among young adult women, wherein EA would supersede anxiety disorder diagnosis in the prediction of future physical health symptoms (see Kraemer et al., 2001). We hypothesized that the presence of an anxiety disorder diagnosis would predict greater physical health symptoms four months later after controlling for baseline health symptoms. Consistent with a proxy risk factor model, however, we also predicted that baseline EA would fully account for the relation between anxiety disorders and future physical health symptoms. If these hypotheses are supported, such findings have the potential to inform the development of targeted treatments that both ease individual suffering and reduce the healthcare costs associated with anxiety disorders.

Method

Participants

Participants were drawn from a large prospective study of emotion dysregulation and sexual revictimization among young adult women in the community. Eligible individuals included all females aged 18–25 who lived in the recruitment catchment areas; there were no other exclusion criteria. One hundred and fifty-one women (M_{age} = 21.75, SD_{age} = 2.02) were recruited from the community in a metropolitan area of the Southern United States without consideration of sexual victimization status (see Procedure for further details). Participants completed assessments at baseline (N = 151) and again four months later (n = 136). Participants were ethnically diverse (75.5% African American; 23.2% White; 2.0% Latina).

Most participants were single (86.1%), full time students (70.2%), and identified as heterosexual (84.1%).

Materials

The *Structured Clinical Interview for DSM-IV Axis I Disorders* (SCID; First, Spitzer, Gibbon, & Williams, 1996) was administered at baseline to assess for the presence of current DSM-IV Axis I disorders. Interviews were conducted by bachelors- or masters-level clinical assessors trained to reliability with the last author ($\kappa \geq .80$). Discrepancies (found in fewer than 10% of cases) were discussed as a group and a consensus was reached. For the purposes of this study, a dichotomous anxiety disorder diagnosis variable was created, with participants meeting diagnostic criteria for any current anxiety disorder scored a 1 and those without any current anxiety disorder scored a 0.

The *Acceptance and Action Questionnaire* (AAQ; Hayes et al., 2004) was used to assess EA. Participants respond to 9 items using a 7-point Likert-type scale (1 = *never true* to 7 = *always true*). AAQ total scores range from 9–63, with high scores indicating more EA. The AAQ has acceptable internal consistency (αs = .70-.86; Arch et al., 2012; Hayes et al., 2004) and demonstrates good concurrent validity with relevant constructs such as thought suppression and mental health symptoms (Hayes et al., 2004). The current study uses AAQ scores provided at the baseline assessment. Although internal consistency in the current sample was somewhat low (Cronbach's α = .60), this is consistent with previous research using this measure (e.g., Andrew & Dulin, 2007).

The *Cohen-Hoberman Inventory of Physical Symptoms—Revised* (CHIPS-R; Campbell, Greeson, Bybee, & Raja, 2008) was used to assess physical health symptoms. Participants were presented with a list of 34 commonly experienced physical symptoms (e.g., "headaches," "dizziness," "stomach pain") and asked to indicate how much each physical health problem had bothered or distressed them during the past four months (including the current day) on a scale from 0 (*not at all*) to 4 (*extreme bother*). Items are summed to create an overall index of physical health symptoms. The current study uses CHIPS-R scores at both the baseline and 4-month follow-up assessments. Internal consistency was good across both assessment waves (αs = .94–.96).

Procedure

All procedures received prior approval by the Institutional Review Boards of the participating institutions. Recruitment methods included both random sampling from the community and community advertisements. First, women within the targeted age range (18–25) were identified from a large commercially-sourced database. Randomly selected individuals from this list were sent a letter inviting them to participate in a longitudinal study of life experiences and adjustment. The recruitment letter contained a description of the project procedures, a post-paid response card to be mailed back by interested individuals, and an enclosed $1 monetary incentive intended to increase response rate (Helgeson, Voss, & Terpening, 2002). Women were also recruited through advertisements for a study on "women's life experiences and adjustment" posted online and throughout the community

(including coffee shops, churches, stores, hospitals, colleges, and clinics). All participants provided written informed consent.

At the baseline assessment, participants completed a diagnostic interview (including the SCID), as well as a series of self-report questionnaires and laboratory tasks. All questionnaires were administered online and completed on a computer in the laboratory. The second assessment (which occurred four months later) included online self-report questionnaires only, and could be completed either at home or in the laboratory. Participants were compensated $75 for the baseline assessment and $25 for the second assessment.

Results

Analyses were conducted using SPSS Statistics 22.0.0.2 for Mac. Inspection of histograms and skewness and kurtosis statistics indicated that CHIPS-R scores were positively skewed and leptokurtic. Square-root transformations reduced skewness and kurtosis to non-significant levels. AAQ scores approximated a normal univariate distribution. No outliers were identified following transformation.

Fifty-seven participants (38%) were diagnosed with a DSM-IV anxiety disorder based upon the SCID interview. Specific phobia was the most frequent diagnosis ($n = 25$), followed by obsessive-compulsive disorder ($n = 18$), posttraumatic stress disorder ($n = 17$), social anxiety disorder ($n = 14$), panic disorder ($n = 7$), and agoraphobia without panic disorder ($n = 6$). Twenty-nine individuals (19%) received at least two separate DSM-IV anxiety disorder diagnoses. Heterosexual participants were less likely to have an anxiety disorder diagnosis (33%) than those who identified as lesbian, gay, or bisexual (70%; $\chi^2(1) = 9.86$, $p = .002$). No other significant differences in demographic characteristics were found between participants with and without an anxiety disorder diagnosis, all ps > .05.

Descriptive statistics of non-transformed scores and bivariate correlations among transformed scores are presented in Table 1. Consistent with the proxy risk factor model (Kraemer et al., 2001), anxiety disorder diagnosis and EA were positively correlated at the baseline assessment. As expected, baseline anxiety disorder diagnosis and EA were significantly positively correlated with physical health symptoms at both baseline and four months later. A hierarchical multiple regression analysis was conducted to examine the relations of baseline anxiety disorder diagnosis and EA to physical health symptoms four months later, when accounting for baseline physical health symptoms. Baseline physical health symptoms, anxiety disorder diagnosis, and EA were entered into the regression sequentially. Normal distribution of the residuals and homoscedasticity assumptions were confirmed through visual inspection. Table 2 presents the full regression model, including the intercept, unstandardized regression coefficients (B), standardized regression coefficients (β), semipartial correlations (sr_i^2), and F, R^2 and change in R^2 for all steps of the regression.

As predicted, baseline anxiety disorder diagnosis was significantly associated with later physical health symptoms when accounting for baseline physical health symptoms, with the inclusion of anxiety disorder diagnosis in the second step significantly improving the model (see Table 2). Likewise, the inclusion of baseline EA in the third step significantly improved

the model, accounting for unique variance in later physical health symptoms above and beyond both baseline physical health symptoms and anxiety disorder diagnosis. Finally, anxiety disorder diagnosis did not remain significantly associated with four month physical health symptoms when EA was included in the model, $t(132) = 1.56$, $p = .122$, 95% CI [−.137, 1.153], consistent with the hypothesis that baseline EA would account for the relation between baseline anxiety disorder diagnosis and later physical health symptoms[1].

Discussion

Young adults with anxiety disorders are at risk for poor long-term outcomes as a result of physical health problems (Chen et al., 2009). Although most anxiety disorders emerge by early adulthood (Kessler et al., 2005) and there is some evidence that early-onset anxiety disorders are related to later physical health conditions (e.g., Scott et al., 2011; Stein et al., 2010), research examining physical health problems among young (vs. older-aged) adults with an anxiety disorder is sparse (McCloughen, Foster, Husw-Thomas, & Delgado, 2012). The present study contributes to this limited evidence base by: (a) further clarifying the relation between anxiety disorders and future physical health symptoms, and (b) identifying EA as a behavioral process that accounts for this relation.

In line with study hypotheses, the presence of an anxiety disorder predicted increased short-term (i.e., four-month) future physical health symptoms, above and beyond baseline physical health symptoms. This finding extends prior research on the relation of anxiety disorders to long-term negative health outcomes (e.g., Chen et al., 2009), suggesting that the relation of anxiety disorders to physical health problems may be evident in the short-term as well. These results highlight the potential utility of systematically assessing and/or screening for physical health symptoms following initial anxiety disorder diagnosis, as the impact of such disorders on physical health outcomes may be more immediate than previously thought. Systematically assessing and monitoring physical health symptoms among individuals with anxiety disorders may facilitate prevention or early intervention efforts aimed at reducing later physical health problems within this population. Nonetheless, it is important to note that we did not collect data on the age of onset or duration of participants' current anxiety disorders; thus, the precise timing of the emergence of physical health problems vis-à-vis the onset of the anxiety disorder and the rate at which such problems occur cannot be determined. Identification of the first onset of anxiety-related pathology would help clarify the short- and long-term relations of clinical levels of anxiety to later physical health symptoms. Additionally, physical health symptoms were not examined as a predictor of future elevated anxiety, a relation with an evidentiary base (Chou, Huang, Goldstein, & Grant, 2013) that could account for at least a portion of the observed relation between anxiety disorder diagnosis and physical health symptoms in this study. Indeed, the likely bidirectional nature of the relation between physical health problems and anxiety complicates efforts to pinpoint the development of each, as well as to disentangle the

[1]The present model was also analyzed by entering EA in the second step and anxiety disorder diagnosis in the third step. EA remained a significant predictor of future physical health symptoms ($\Delta R^2 = .032$, $p < .01$), and inclusion of anxiety disorder diagnosis did not result in a significant improvement in the model ($\Delta R^2 = .007$, $p > .05$). In the parlance of the proxy risk factor model, EA dominated anxiety disorder diagnosis in the prediction of physical health symptoms (Kraemer et al., 2001). Full analyses are available by contacting the first author.

processes that link anxiety diagnoses and physical health problems (Duric, Clayton, Leon, Yuan, 2016). Potential reciprocal relations between anxiety pathology and physical health symptoms remain an important area for future research.

As hypothesized, EA was uniquely related to future physical health symptoms (above and beyond anxiety disorder status), accounting for more unique variance in later physical health symptoms than anxiety disorder status alone. More importantly, anxiety disorder diagnostic status no longer predicted physical health symptoms once EA was added to the model (whereas the addition of anxiety disorder status to a model including EA did not reduce the strength of the relation of EA to physical health symptoms). These findings support our hypothesized model, suggesting that anxiety disorder diagnosis likely functions as a proxy risk factor (Kraemer et al., 2001) for EA when predicting future physical health symptoms. Though the relation between EA and anxiety disorder status is likely reciprocal, our results suggest that how one responds to internal and external stimuli (i.e., accepting vs. avoidant) may have a greater influence on health-related outcomes than anxiety disorder status *per se*. Particularly when the goal of treatment is to improve both anxiety and physical health symptoms, behavioral therapies that teach strategies for reducing unhelpful avoidant behavior may be more efficient than treatments that focus on the elimination of anxiety symptoms.

One important next step for future research in this area will be to examine the mediating role of EA in improvements in physical health outcomes over the course of treatments for anxiety disorders. For example, Acceptance and Commitment Therapy (ACT; Hayes et al., 2012) targets EA and is efficacious and effective for addressing anxiety disorders (Bluett, Homan, Morrison, Levin, & Twohig, 2014; Landy, Schneider, & Arch, 2015; Swain, Hancock, Hainsworth, & Bowman, 2013) and various physical health problems (A-Tjak et al., 2015), including chronic medical conditions (Dindo, 2015) and chronic pain (Hann & McCracken, 2014; Veehof, Oskam, Schreurs, & Bohlmeijer, 2011). ACT has been successfully disseminated through brief workshops (e.g., Gregg, Callaghan, Hayes, & Glenn-Lawson, 2007; Lillis, Hayes, Bunting, & Masuda 2009; Sheppard, Forsyth, Hickling, & Bianchi, 2010) as well as group-based (McCracken, Sato, & Taylor, 2013) interventions. This makes ACT conducive to primary care settings (Dindo, 2015), which is often the only venue where individuals with elevated levels of anxiety access health care services (Regier et al., 1993). To the best of our knowledge, however, ACT has not been evaluated in samples with co-occurring anxiety disorders and physical health conditions. Future research examining the utility of ACT (or other interventions that target EA) for these co-occurring problems is needed. Early interventions aimed at targeting EA may help highly anxious patients learn more adaptive ways of responding to internal experiences, which, in turn, may prevent the development of physical health problems or improve recovery from and management of physical health problems that do occur.

Several limitations of the current study warrant discussion. First, the sample was composed of young adult women; thus, the extent to which these findings will generalize to men or more diverse age groups is unknown. Likewise, approximately 75% of the sample identified as African American. Although the racial makeup of our sample closely mirrored recent US census statistics of the geographical area (see U.S. Census Bureau, 2010), our results may

not generalize to members of other racial or ethnic groups. Nonetheless, our findings highlight potential negative health consequences of anxiety disorders and EA among African Americans, a population with elevated rates of both mental and physical health problems (Centers for Disease Control and Prevention, 2012; 2013). In addition, this study assessed physical health symptoms (vs. physical health conditions or severe physical health problems) in a nonclinical community sample with a relatively low average level of reported symptoms. As such, our results may not extend to individuals with more serious physical health problems. Inclusion of patient populations in future research, particularly individuals with chronic physical health conditions, may clarify the relations of EA and anxiety disorders to major physical health problems.

Furthermore, although results provide support for the hypothesized proxy risk factor model and suggest that EA may be a global risk factor for later physical health symptoms relative to an anxiety disorder diagnosis, the effect size of the observed relation between EA and physical health symptoms was small and much of the variance in physical health symptoms remained unexplained. Future research is needed to examine other factors (e.g., adherence to treatment recommendations, early stressful life events, dysregulated central nervous system processes; see Bautista, Vera-Cala, Colombo, & Smith, 2012; Duric et al., 2016; Faravelli et al., 2012) that may relate to later physical health symptoms in young adults with and without anxiety disorders.

There are also some limitations associated with our anxiety disorder and general assessment procedures. Although the use of an empirically supported structured diagnostic interview is a strength of this study, this interview was administered at baseline only. Thus, whether participants met criteria for a current anxiety disorder four months later, or the implications of this for the observed relations, remains unclear. The administration of structured diagnostic interviews at multiple time points over the course of a longitudinal study would provide a better understanding of the interrelations of anxiety disorders and physical health problems over time. In addition, our use of a dichotomous anxiety disorder variable may have limited our statistical power or influenced our findings relative to the use of a continuous assessment of anxiety pathology. Given past findings of a large-sized relation between our measure of EA and continuous measures of anxiety (e.g., Kashdan et al., 2006; see also Chawla & Ostafin, 2007; Hayes, Luoma, Bond, Masuda, & Lillis, 2006), use of a continuous assessment of anxiety in future research would facilitate examination of the predictive utility of EA relative to anxiety severity more broadly. The use of a self-report measure of physical health symptoms is also a limitation; future research should examine the relations reported herein in the context of medical diagnoses provided by physicians or captured through medical chart review. Furthermore, given that many factors in a person's day may influence self-reports of EA and physical health symptoms, use of more intensive assessments (e.g., a daily diary design) may further clarify our findings and the precise interrelations among anxiety, EA, and physical health symptoms.

It is also important to note that we did not account for the presence of co-occurring anxiety disorders. Identification of the impact of EA on physical illness in individuals who experience multiple anxiety disorders is an important area for future research. Additionally, although the use of a prospective design allows us to clarify the temporal relations between

both anxiety disorders and EA and later physical health symptoms, results cannot speak to the causal role of these factors in physical health problems. Replications of this research, as well as examinations of the relations reported herein over a longer course of time (e.g., 1 to 2 years), will increase confidence in the present findings. Finally, the low internal consistency of the AAQ warrants mention. Low reliability of this instrument has been found in a number of other studies (Bond et al., 2011). Nonetheless, the AAQ has demonstrated clinical and research utility across a variety of samples (see Hayes et al., 2006; Ruiz, 2010) and, in this study, provides valuable insight into a behavioral process that may underlie the relation between anxiety disorder diagnoses and physical health problems. Future studies attempting to replicate our findings would benefit from using more psychometrically sound measures of EA, such as the Acceptance and Action Questionnaire-II (AAQ-II; Bond et al., 2011) or behavioral measures (e.g., the Computerized Paced Auditory Serial Addition Task; Gratz, Bornovalova, Delany-Brumsey, Nick, & Lejuez, 2007).

This study represents an initial step in research aimed at alleviating the physical suffering experienced by some individuals with anxiety disorders. Our results highlight the role of EA as one possible factor accounting for the increased physical health symptoms associated with anxiety disorder status. As such, acceptance-based behavioral therapies such as ACT (which specifically targets EA) may be an efficient strategy for improving physical health outcomes among anxiety disordered populations. Further, although this study highlights one factor that may explain the heightened physical health problems observed among individuals with anxiety disorders, linkages between anxiety disorder status and physical health are undoubtedly complex. Thus, further work is needed to identify additional behavioral and physiological processes that may guide the development of effective complementary or alternative treatment strategies. Research along these lines has the potential to improve the overall wellbeing of individuals who experience anxiety disorders while also reducing healthcare burden associated with compromised physical health in this population.

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Highlights

- Women (M_{age} = 21.75) assessed at baseline (N = 151) and 4-months later (n = 136)
- Baseline anxiety disorder diagnosis related to baseline experiential avoidance (EA)
- Anxiety disorder diagnosis related to physical health symptoms four months later
- EA fully accounted for the relation of anxiety disorders to physical health symptoms
- Anxiety disorders may be a proxy for EA in the risk for physical health problems

Table 1

Descriptive Statistics and Bivariate Relations among Anxiety Diagnosis, Physical Health Symptoms, and Experiential Avoidance

	With Anxiety Diagnosis (n = 57)	Without Anxiety Diagnosis (n = 94)	Total Sample (n = 151)	Bivariate Relations		
Variable	***M* (SD)**	***M* (SD)**	***M* (SD)**	**1**	**2**	**3**
1. Anxiety Disorder Diagnosis	-	-	-	-		
2. Baseline Health Symptoms	30.18 (25.60)	14.56 (15.47)	20.46 (21.23)	.37**	-	
3. 4-Month Health Symptoms[a]	30.68 (30.15)	12.77 (14.21)	19.74 (23.44)	.39**	.72**	-
4. Experiential Avoidance	35.88 (8.25)	30.80 (6.42)	32.72 (7.55)	.33**	.30**	.38**

Note. Anxiety disorder diagnosis = baseline presence of an anxiety disorder diagnosis on the SCID (Absent = 0; Present = 1). Experiential avoidance assessed at baseline.

[a] n = 136

** $p < .001$

Table 2

Hierarchical Regression Analysis Examining the Relations of Baseline Physical Health Symptoms, Anxiety Diagnosis, and Experiential Avoidance to Physical Health Symptoms Four Months Later

Variable	*B*	*SE B*	β	sr_i^2	*F*	R^2 (ΔR^2)
	Step 1				**147.39***	**.524 (.524)**
Intercept	0.431	0.306				
Baseline Physical Health	0.806	0.066	0.724	.524**		
Symptoms	Step 2				4.19*	.538 (.015)
Intercept	0.397	0.303				
Baseline Physical Health Symptoms	0.751	0.071	0.674			
Anxiety Disorder Diagnosis	0.660	0.322	0.130	.014*		
	Step 3				4.54*	.554 (.015)
Intercept	−0.831	0.650				
Baseline Physical Health Symptoms	0.712	0.072	0.640			
Anxiety Disorder Diagnosis	0.508	0.326	0.100			
Experiential Avoidance	0.044	0.021	0.135	.016*		

Note. SE = Standard error; sr_I^2 = semipartial correlations; Baseline and 4-month physical health symptoms are square root transformed. Anxiety disorder diagnosis = baseline presence of an anxiety disorder diagnosis on the SCID (Absent = 0; Present = 1). Experiential avoidance assessed at baseline.

* $p < .05$.

** $p < .001$.