Translation and Psychometric Testing of the Chinese Version of the Multidimensional Assessment of Interoceptive Awareness

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ABSTRACT

Background: Mind–body interventions are used to alleviate physical and psychological symptoms. The multidimensional assessment of interoceptive awareness (MAIA), which is used to self-report the effects of mind–body interventions, is not currently available in Chinese.

Purpose: This study aimed to translate the MAIA from English into Chinese (MAIA-C) and to examine the psychometric properties of the MAIA-C.

Methods: This was a methodological study. The MAIA was translated forward and backward systematically, and content validity was assessed by a panel of experts. A convenience sample of adult participants with mind–body practice was recruited from social clubs in Taiwan. The MAIA-C was administered to study participants. Internal consistency and test–retest reliability were tested using Cronbach's alpha and intraclass correlation coefficient. Construct validity was assessed in two ways: using confirmatory factor analysis and using the differences between the known groups to divide the sample into two groups of highly experienced and less experienced participants.

Results: The complete data for the 294 participants were analyzed. The eight-factor structure of the MAIA-C was confirmed. Cronbach's α was .91 overall and .46–.88 for the individual scales of the instrument. Intraclass correlation coefficient and composite reliability for the scales ranged from .60 to .85 and .55 to .87, respectively. The result of confirmatory factor analysis revealed a fair fit of the model to the data with a root mean square error of approximation of .076 and a comparative fit index of .95. Significant differences were found for the seven scales between the two groups.

Conclusions/Implications for Practice: The MAIA-C showed acceptable reliability and validity in psychometric testing. Therefore, this scale may be used in studies that assess interoceptive awareness in Chinese-speaking populations who are undergoing mind–body interventions.

Key Words:
mind–body, multidimensional assessment of interoceptive awareness (MAIA), scale, reliability, validity.

Introduction

Mind–body interventions focus on the interactions between mind, body, and behavior and are currently in widespread use to improve health (Wolsko, Eisenberg, Davis, & Phillips, 2004). This type of intervention includes qigong, tai chi, yoga, breathing practices, relaxation, meditation, imagery, mindfulness, hypnosis, stress management, and biofeedback (National Center for Complementary and Integrative Health, 2015). Numerous studies have shown the health benefits of tai chi in terms of improving exercise tolerance, quality of life (Yan, Guo, Yao, & Pan, 2013), and emotional and social well-being (Robins et al., 2006); of yoga in terms of improving sleep quality, depression (Kinser, Elswick, & Kornstein, 2014), and functional performance (Donesky-Cuenco, Nguyen, Paul, & Carrieri-Kohlman, 2009); and of mindfulness and meditation in terms of improving the self-regulation of attention (Moore, Gruber, Derose, & Malinowski, 2012), emotional function (Chan, Giardino, & Larson, 2015), and breathing patterns (Robert McComb, Tacon, Randolph, & Caldera, 2004).

The psychological mechanisms of action for mind–body interventions have rarely been assessed. Furthermore, these mechanisms require specific and feasible measurement tools. Interoceptive awareness has been suggested as one of the several potential mechanisms for mind–body interventions (Mehling et al., 2011). Interoceptive awareness refers to

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one's conscious and internal perception of changes in heart rate, breathing, and autonomic nervous system sensations (Khalsa et al., 2008). Interoceptive awareness is at the interface of mind and body. Therefore, improving this type of awareness may benefit health. Interoceptive awareness has been measured objectively as interoceptive accuracy, which has not been shown to be sensitive to change through the use of mind–body interventions (Parkin et al., 2014). The closely related, partly overlapping, and equally complex construct of bodily awareness is the awareness of interoceptive and proprioceptive body signals. This construct has been measured using self-report scales. However, these scales are inadequate, as they are limited either by reduced dimensionality or by their conceptualization as proxy measures for anxiety (Mehling et al., 2009).

Interoception has been studied intensely in psychophysiology (Khalsa et al., 2008), neuroscience (Khalsa, Rudrauf, Feinstein, & Tranel, 2009), and cognitive science (Ainley, Maister, Brokfeld, Farmer, & Tsakiris, 2013). Interoception has been associated with emotion regulation (van 't Wout, Faught, & Menino, 2013) and attention (Ainley et al., 2013). All of these studies assessed interoceptive accuracy, which is only one aspect of the much broader concept of interoception and its awareness (Garfinkel, Seth, Barrett, Suzuki, & Critchley, 2015). To investigate the potential effects of mind–body interventions, the assessment of interoceptive accuracy by objective measures is important, although conceptually limited (Bornemann, Herbert, Mehling, & Singer, 2015).

The multidimensional assessment of interoceptive awareness (MAIA) is a self-report questionnaire that was developed to address some of these limitations and to capture any changes in the multiple dimensions of interoceptive body awareness that individuals may experience with mind–body interventions (Mehling et al., 2012). The MAIA includes eight scales that separately assess the awareness of sensations internally, the quality of one's attention, the attitude toward and behavioral reaction to bodily sensations, and the individual style and capacity for mind–body integration. The eight MAIA scales are Noticing, Not-distracting, Not-worrying, Attention regulation, Emotional awareness, Self-regulation, Body listening, and Trusting. To apply the MAIA in a Chinese-speaking population, this study was undertaken to systematically translate this instrument and study the psychometric properties of the Chinese version.

Methods

Translation

First, permission to translate the MAIA was obtained from the original author of the instrument, Dr. Wolf Mehling. Next, a systematic forward–backward translation of the MAIA from the original English into Chinese was conducted using the decentered translations strategy to retain the equivalency of meanings across the two languages and cultural settings (Huang, Hsueh, Lu, & Huang, 2016; Yeh & Chen, 1998). This procedure followed the principle of cross-cultural adaptation of self-report measures for different languages (Beaton, Bombardier, Guillemin, & Ferraz, 2000). Five native Chinese speakers who spoke English and were familiar with both cultures each conducted a forward translation of the instrument into Chinese. Two of the translators were physicians, and three were university professors with expertise in health and exercise. Discrepancies among their five translations were thoroughly discussed and amended to produce the most appropriate and adequate translation (Peters & Passchier, 2006). The authors made sure that the forward-translated version was identical in meaning to the original English version. A medical school professor from the United States whose first language is Chinese, and who studies mind–body approaches, was consulted to review the agreed-upon forward-translated Chinese version of the MAIA.

Two individuals, an English-language college teacher trained in linguistics in Taiwan and a U.S.-based physician specializing in physical medicine and rehabilitation, back translated the forward-translated Chinese version into English independently. Each was blinded to the original English version of the MAIA. The lead developer of the MAIA was consulted to review the back-translation to ensure the literal and conceptual equivalence and to address discrepancies between the original and back-translated versions. All of the remaining discrepancies were resolved in thorough discussions between the authors to assure conceptual and semantic equivalence with the original version of the MAIA. The preliminary version of the MAIA-C was evaluated for readability and acceptability using cognitive testing with five teenage Chinese speakers and three senior nursing experts in a Taiwanese hospital, which resulted in only minor modifications to the final MAIA-C.

Research Design

This methodological study of the MAIA-C was designed by following the current principles in measurement theory (Waltz, Strickland, & Lenz, 2010). Reliability was examined as internal consistency, test–retest, and construct reliability. Validity was examined as content and construct validity.

Sampling

A convenience sample was recruited. The inclusion criteria were healthy people aged 20 years or older who participated in social clubs that involved tai chi, qigong, martial arts, yoga, mindfulness, or meditation and who were fluent in speaking, reading, and writing Chinese. Those with cognitive impairments were excluded from the study. A panel of experts in mind–body practices and interventions served as content validators to examine the content validity of the translation. To determine internal consistency reliability and to test construct validity using factor analysis, a minimum sample size of 300 participants was recommended (Nunnally & Bernstein, 1994). Three hundred fifteen volunteers were recruited to accommodate an attrition rate of up to 5% and the potential of incomplete data submissions. To assess test–retest reliability, 38 participants filled out the MAIA-C twice at an interval of 2 weeks. Five participants were invited to participate in a cognitive interview session, which assessed their perceptions regarding the ease of comprehension, relevance, and clarity of expression of each individual item.

Ethical Considerations

Study approval was obtained from the research ethics committee of the National Taiwan University Hospital (Ref. no. 201304063RINC). Participants who met the inclusion criteria were invited to fill out a demographic information sheet and the MAIA-C. Written informed consent was obtained after detailed explanation of the purpose and procedures of this study. This study used ID numbers rather than participant names on each questionnaire to ensure participant anonymity. Completing the questionnaires took between 10 and 15 minutes. Participants were free to withdraw from the study at any time without further consequences. Data were collected from June 2013 to March 2014.

Reliability/Validity of the Instrument

The original MAIA includes 32 items categorized into the following eight scales, as noted. Each item was scored on a 6-point Likert scale, ranging from 0 (never) to 5 (always). Each scale received an average score of 3–7 points, with higher scores indicating more positively appraised interoceptive awareness. Reliability and validity of the MAIA have been confirmed in a U.S. sample (Mehling et al., 2012, 2013). Internal consistency reliability appears adequate, with Cronbach's alphas ranging from .66 to .82. An eight-factor model fitted the data with a comparative fit index of .89 and a root mean square error of approximation of .06.

Data Collection and Data Analysis

Statistical analyses were conducted using IBM SPSS Statistics for Windows 20.0 (IBM Inc., Armonk, NY, USA) and the Linear Structural Relations model version 8.43 (Scientific Software International, Lincolnwood, IL, USA). To conduct a contrasted group approach, study participants were divided into two groups by level of experience in mind–body approaches, which was assessed by the number of years of practice. Participants who had practiced the primary type of exercise for less than 5 years were grouped into the "less experienced" (LE) group, and the remaining participants were grouped into the "highly experienced" (HE) group. Descriptive statistics were applied to identify the characteristics of the participants. Differences between groups were then examined using *t* tests for continuous variables and the chi-square or Fisher's exact test for categorical variables. The item-objective relevance was assessed using the 4-point content validity index (CVI) at both the item (I-CVI) and scale (S-CVI) levels to determine content validity (Waltz et al., 2010). I-CVI levels of .78 or higher and S-CVI levels of .90 or higher are recommended (Polit & Beck, 2010).

The cognitive interviews that were conducted for the current study were in-depth interviews that assessed the participants' understanding of the questions and specific terms and identified difficulties with the response choices (Mehling et al., 2012). Internal consistency reliability was assessed using Cronbach's alpha, with values of .70–.90 viewed as acceptable (Nunnally & Bernstein, 1994). Test–retest reliability was assessed using the intraclass correlation coefficient (ICC) with a two-way mixed effects model, which establishes the reliability of collecting data from raters that are not randomly selected (Portney & Watkins, 2009). ICC values of .40–.75 were interpreted as representing fair-to-good agreement (Fleiss, Levin, & Paik, 2004). Construct reliability was assessed using standardized factor loadings and error variances (Raykov, 1997), with values above .5 (Raine-Eudy, 2000) or .6 (Bagozzi & Yi, 1988) generally viewed as acceptable, respectively.

A contrasted group approach was used to compare the two groups of different experience levels using the *t* test as well as to assess the ability of the MAIA-C to detect differences between the known groups (Waltz et al., 2010). Construct validity was assessed using confirmatory factor analysis (CFA), with minimal factor loadings of .3. The χ^2 test, χ^2/df ratio (<5), goodness-of-fit index (>.90), adjusted goodness-of-fit index (>.90), comparative fit index (>.90), root mean square residual (<.5), root mean square error of approximation (<.08), and critical *N* (>200) were used to determine a model fit for the CFA that provided a robust maximum likelihood estimation (Yeh & Gau, 1999). A model improvement using model modification was conducted as needed. The selection of parameters to be freed was based on two rules: (a) it should be consistent with the theory, and (b) parameters must be selected that have large expected changes in χ^2 and in the other parameters (Kaplan, 1990) and that are suggested by the Linear Structural Relations program. *P* values of less than .05 were considered statistically significant.

Results

Participant Characteristics

Of the 315 participants recruited, 21 were excluded from data analysis because of more than 12 missing values on the 32-item MAIA-C. Therefore, 294 (93.3%) responses were used in further analysis. Table 1 presents the demographic characteristics for both groups, with 218 (74.1%) in the LE group and 76 (25.9%) in the HE group. The mean age of participants was 45.2 ± 13.1 years. Most participants were female (69.7%), college educated (57.5%), married (63.0%), and religious (56.5%) and exercised regularly (74.8%). The two groups were significantly different in terms of age, religious affiliation, health status, life satisfaction,

TABLE 1.
Demographic Characteristics for the Two Groups (N = 294)

Variable	Total		LE (*n* = 218)		HE (*n* = 76)		t/χ^2	*p*
	n	%	*n*	%	*n*	%		
Age (years), *M* and *SD*	45.2	13.1	44.3	13.3	47.9	12.0	$t = -2.08$	.04
Sex							$\chi^2 = .20^{\#}$	.66
Female	205	69.7	153	70.2	52	68.4		
Male	86	29.3	62	28.4	24	31.6		
Not provided	3	1.0	3	1.4	0	0		
Education							$\chi^2 = 1.68$	.43
Less than college	74	25.2	56	25.6	18	23.8		
College	169	57.5	122	56.0	47	61.8		
Graduate	48	16.3	39	17.9	9	11.8		
Not provided	3	1.0	1	0.5	2	2.6		
Marital status							$\chi^2 = .06^{\#}$	.89
Married	185	63.0	139	63.7	46	60.6		
Others	103	35.0	76	34.9	27	35.5		
Not provided	6	2.0	3	1.4	3	3.9		
Religious							$\chi^2 = 4.26^{\#}$	.04
Yes	166	56.5	114	52.3	52	68.4		
No	58	19.7	48	22.0	10	13.2		
Not provided	70	23.8	56	25.7	14	18.4		
Health status (*M* and *SD*)	3.4	0.7	3.3	0.7	3.6	0.7	$t = -3.23$	.001
Life satisfaction (*M* and *SD*)	3.4	0.8	3.3	0.7	3.7	0.7	$t = -3.99$	.001
Years of exercise (*M* and *SD*)	4.9	5.3	1.9	1.1	10.0	5.6	$t = -12.36$	<.001
Frequency							$\chi^2 = 5.13^{\#}$	.03
Regular	220	74.8	155	71.1	65	85.6		
Not regular	60	20.4	51	23.4	9	11.8		
Not provided	14	4.8	12	5.5	2	2.6		
Type of exercise (multiple choices)								
Tai chi	61	16.5	39	15.1	22	20.0		
Qigong	37	10.0	23	8.9	14	12.7		
Martial arts	16	4.3	9	3.5	7	6.4		
Yoga	148	40.1	110	42.6	37	33.6		
Mindfulness	47	12.7	36	14.0	11	10.0		
Meditation	60	16.3	41	15.9	19	17.3		

Note. LE = less experienced; HE = highly experienced. [#]Fisher's exact test.

years of exercise and frequency of activity but were significantly similar in terms of sex, education, and marital status.

Translation and Content Validity

Three experts assessed all items as quite relevant or highly relevant to the objectives. Both the I-CVI and the S-CVI earned scores of 1. However, the experts identified the wording for Item 6 as requiring revision.

Reliability

Table 2 shows the results for the reliability of the MAIA-C. The Cronbach's alpha was .91 for the overall scale and .46–.88 for the individual scales. The ICC ranged from .60 to .85, and construct reliability ranged from .55 to .87.

Validity

Table 3 shows mean scale scores and standard deviations. Groups were significantly different on all scales except the Not-distracting scale. Table 4 shows the results of the CFA, which revealed a fair fit of the model to the data. Standardized factor loadings ranged from .03 to .85, and the error variances ranged from .27 to 1, with the exception of Item 10, which loaded <.3, indicating that this item did not contribute significantly to the scale. Model modification was performed according to the two highest modification indices. First, the residuals of Items 25 and 26 were closely correlated; Model 1 in Table 4 explicitly allows these two residuals to be correlated to each other. Item 25 states: "I can use my breath to reduce tension," whereas Item 26 states: "When I am caught up in thoughts,

TABLE 2.
Reliability of the MAIA-C

Scale	Item	*n*	Alpha	ICC	95% CI	Construct
Noticing	1–4	4	.76	.68	0.38, 0.83	.77
Not-distracting	5–7	3	.58	.60	0.22, 0.79	.62
Not-worrying	8–10	3	.46	.73	0.47, 0.85	.55
Attention regulation	11–17	7	.85	.85	0.71, 0.92	.86
Emotional awareness	18–22	5	.88	.84	0.68, 0.91	.87
Self-regulation	23–26	4	.81	.82	0.64, 0.90	.82
Body listening	27–29	3	.87	.83	0.67, 0.91	.86
Trusting	30–32	3	.86	.83	0.66, 0.91	.81

Note. MAIA-C = multidimensional assessment of interoceptive awareness in Chinese; ICC = intraclass correlation coefficient.

I can calm my mind by focusing on my body/breathing." The content of these two Self-regulation items is similar in that awareness of breathing is used in both items as a tool in self-regulation. Second, the residuals of Items 11 and 12 were closely correlated, which is permitted in Model 2. Item 11 states: "I can pay attention to my breath without being distracted by things happening around me," whereas Item 12 states: "I can maintain awareness of my inner bodily sensations even when there is a lot going on around me." The content of these two Attention regulation items is similar in that attention is kept on the body or breathing despite potential distractions. Model fit significantly improved after the item residuals were allowed to correlate with each other.

Discussion

This study aimed to translate the MAIA from English into traditional Chinese and to assess the reliability and validity of the MAIA-C. The results support the reliability and validity of most of the MAIA-C scales. The MAIA-C showed high content validity; overall internal consistency reliability; and acceptable test–retest reliability, composite reliability, and construct validity in individuals with mind–body practice. The MAIA-C received high scores for the I-CVI and S-CVI from a panel of experts. Experts judged all of the items as quite relevant or highly relevant and found that the Chinese translation of Item 6, "I distract myself from sensations of discomfort," required revision, although the participants in the cognitive interviews did not find any difficulties with this item. The MAIA-C satisfied content validation, with its items representing the content domains and concepts.

The Cronbach's alpha for the overall scale indicates high internal consistency reliability. The Cronbach's alpha for six of the eight scales was in the acceptable range, with only the Not-distracting and Not-worrying falling below .7. This result is similar to the MAIA in the original English version (Mehling et al., 2012, 2013), the German version (Bornemann et al., 2015), the Spanish version (Valenzuela-Moguillansky & Reyes-Reyes, 2015), and the Italian version (Calí, Ambrosini, Picconi, Mehling, & Committeri, 2015). We share the opinion of Valenzuela-Moguillansky and Reyes-Reyes (2015) that these two scales contain an

TABLE 3.
Between-Group Differences in the MAIA-C Scales (N = 294)

	Total		LE (*n* = 218)		HE (*n* = 76)			
Scale	Mean	*SD*	Mean	*SD*	Mean	*SD*	*t*	*p*
Noticing	3.59	0.86	3.51	0.83	3.81	0.91	−2.76	.01
Not-distracting	2.07	0.94	2.05	0.94	2.13	0.94	−0.58	.56
Not-worrying	1.98	0.81	1.91	0.78	2.18	0.87	−2.45	.02
Attention regulation	3.11	0.79	3.03	0.76	3.34	0.77	−3.05	.003
Emotional awareness	3.53	0.88	3.47	0.87	3.70	0.88	−2.06	.04
Self-regulation	3.20	0.91	3.08	0.91	3.55	0.80	−3.98	<.001
Body listening	3.07	0.97	2.95	0.92	3.40	1.05	−3.54	.001
Trusting	3.44	0.88	3.36	0.89	3.68	0.82	−2.74	.006

Note. MAIA-C = multidimensional assessment of interoceptive awareness in Chinese; LE = less experienced; HE = highly experienced.

TABLE 4.
Confirmatory Factor Analysis Fit Indices of MAIA-C

Model	χ^2	*p*	*df*	χ^2/df	RMSEA	95% CI	RMR	GFI	AGFI	CFI	RFI	CN
Eight-factor model	1190.95	<.001	436	2.73	.076	0.07, 0.08	.097	.80	.76	.95	.92	125.9
Model 1	1055.66	<.001	435	2.43	.070	0.06, 0.08	.095	.82	.78	.96	.93	134.8
Model 2	978.27	<.001	434	2.25	.065	0.06, 0.07	.095	.83	.79	.96	.93	143.5

Note. MAIA-C = multidimensional assessment of interoceptive awareness in Chinese; RMSEA = root mean square error of approximation; CI = confidence interval; RMR = root mean square residual; GFI = goodness-of-fit index; AGFI = adjusted goodness-of-fit index; CFI = comparative fit index; RFI = relative fit index; CN = critical *N*.

overly small number of items (three) and that all but one are reverse scored. Cronbach's alphas depend on the number of scale items. Therefore, low item numbers may indicate low internal consistency reliability (Yeh, 2002). Although it has been suggested to add more items if scale alphas are <.8 (Polit & Beck, 2010), based on the content validity considerations and questionnaire burden, we decided to retain the original items without adding more items. The composite reliability of all the eight scales showed acceptable consistency. The ICC for scales showed acceptable test–retest reliability, which is more sensitive to detecting systematic error (Yen & Lo, 2002). The Not-distracting scale conceptualizes the tendency not to ignore or distract oneself from discomfort and includes three items that assess the level of one's body awareness and the degree of coping with discomfort. The Not-worrying scale focuses on emotional distress or worry from discomfort, which involves three items to assess the level of one's negative emotion or discomfort-related worry. Therefore, the survey takers may be confused regarding the actual intent of the above mentioned scales.

The CFA showed a moderate model fit with indices, which is similar to the original version (Mehling et al., 2012, 2013). The factor loading of Item 10, "I can notice an unpleasant body sensation without worrying about it," was <.3, indicating that the item did not contribute to the scale. This item was the only positive-scored item of the Not-worrying scale, with the other two items being reversed. Making the direction for this item consistent with the other items in the scale may improve its consistency reliability (Currey, Callahan, & DeVellis, 2002). Model modifications were made for close between-item correlations. However, Models 1 and 2 were similar to the eight-factor model, which suggests the requirement of validation by using exploratory factor analysis. This scale may also need revision in future studies. Similar to the original version, the contrasting group validity showed strong differences between the LE and HE groups, with the HE group consistently reporting higher scores for interoceptive awareness (Mehling et al., 2012).

Mean scores for the Not-distracting and Not-worrying scales in the MAIA-C were lower than those in the original English-language version. This may indicate the potential effect of cultural differences between Americans and Taiwanese. Regarding distraction, the relief of pain using acupuncture, massage, hot packing, Chinese herbal medicine, passive pain endurance, and keeping busy with other things as a distraction from pain are coping methods that are widely familiar to Taiwanese (and, by extension, most ethnic Chinese) for dealing with uncomfortable states (Lee, Cheng, Wang, & Lin, 2008; Yu & Yu, 2003). Nurses in Taiwan teach patients with pain to watch television or listen to music. Previous studies have shown that active distraction (electronic gaming systems) was associated with greater reductions in pain than passive distraction (television) or no distraction (Jameson, Trevena, & Swain, 2011). However, distraction has also been questioned as a means for coping with chronic pain (Goubert, Crombez, Eccleston, & Devulder, 2004). The mind–body activities that Americans typically use to cope with discomfort include exercise (35%) such as walks and tai chi; cognitive methods (27%) such as watching television, reading, and listening to music; and religious activities (21%) such as praying (Barry et al., 2004). Therefore, American and ethnically Chinese cultures may cope with discomfort somewhat differently. The score for Not-worrying in the MAIA-C was lower than that for the original version, which was tested on English speakers (Mehling et al., 2012). Regarding worrying, the healthcare services in Taiwan are accessible and affordable via the National Health Insurance Administration. Taiwanese had an average of 15 clinic visits per person in 2012 and, as we may speculate, may not typically try to calm their minds when they feel uncomfortable. Therefore, the mean scores for Not-worrying on the MAIA-C may be influenced by the national healthcare environment in Taiwan. Cultural or regional differences suggest the need to modify these scales accordingly.

Two limitations of this study must be considered. First, we did not test for cross-culture validity. Future research should test the validity of the MAIA and the MAIA-C simultaneously. Second, all of the study participants were from Taiwan and therefore may not represent other Chinese-speaking populations. In future studies, the study population may be expanded to assess the applicability of the MAIA-C to all ethnically Chinese populations.

Conclusions

The MAIA-C was shown as having acceptable reliability and validity. Therefore, the MAIA-C is a valid tool for assessing self-reported interoceptive awareness among Chinese-speaking individuals who undergo mind–body interventions—especially tai chi, qigong, martial arts, yoga, mindfulness, and meditation in community settings. However, further study is necessary to validate this instrument in Chinese-speaking populations outside Taiwan.

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中文版多維度內在感受覺察量表之翻譯及測試

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背　景　身心介入可緩解生理及心理之症狀，而其介入成效可使用多維度內在感受覺察量表來評估。然而，目前缺乏該量表之中文版。

目　的　本研究旨在翻譯多維度內在感受覺察量表，並且測試其信度與效度。

方　法　本研究採方法學研究設計，以系統性翻譯及回覆翻譯量表，並由專家群評估內容效度。研究對象為參與身心活動社團的成人，採方便取樣。內在一致性及再測信度分別以Cronbach's α及組內相關係數呈現。建構效度採驗證性因素分析，並檢定經驗多與經驗少的身心活動已知族群的差異。

結　果　以294位參與者的資料確認中文版多維度內在感受覺察量表共有八構面。整體量表及各次量表的Cronbach's α分別為 .91及 .46～ .88。組內相關係數及組合信度分別為 .60～ .85及 .55～ .87。驗證性因素分析呈現適配結果，近似誤差均方根及比較適配指標分別為 .076及 .95。經驗多與經驗少的身心活動參與者在七個次量表有顯著差異。

結　論／實務應用　中文版多維度內在感受覺察量表具有可接受的信度與效度，且可用於華語族群之身心介入後的內在感受覺察評估。

關鍵詞：身心、多維度內在感受覺察、量表、信度、效度。

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