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Lower-order anxiety sensitivity and intolerance of uncertainty dimensions operate as specific vulnerabilities for social anxiety and depression within a hierarchical model☆

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ABSTRACT

Within a hierarchical framework for depressive and anxiety disorders, negative affect (NA) is posited to be indirectly related to social anxiety and depression through cognitive vulnerabilities, including intolerance of uncertainty (IU) and anxiety sensitivity (AS). However, few prior studies have considered whether the lower-order dimensions of IU (i.e., prospective and inhibitory IU) and AS (i.e., physical, cognitive, and social concerns) better explain the indirect relation between NA and social anxiety and depression. The indirect relations between NA and social anxiety and depression through these cognitive vulnerabilities were examined using structural equation modeling in a clinical sample (N = 298). NA and social anxiety symptoms were indirectly related through AS social concerns and inhibitory IU, although a direct effect of NA was also found. Only AS social concerns explained the relation between NA and a social anxiety disorder diagnosis. AS cognitive concerns was the only cognitive vulnerability factor to indirectly explain the relation between NA and depressive symptoms, although a direct effect of NA was also found. These findings suggest that the lower-order dimensions of AS and IU demonstrate more specific and less transdiagnostic associations with social anxiety and depression.

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Depressive disorders and social anxiety disorder (SAD) are among the most common psychiatric disorders in the United States, with lifetime prevalence rates of approximately 17% and 11%, respectively (Kessler, Petukhova, Sampson, Zaslavsky, & Wittchen, 2012). SAD is characterized by an excessive fear and avoidance of social and/or performance situations in which the individual is fearful of evaluation or rejection by others (American Psychiatric Association, 2013). The essential features of depressive disorders are a persistent low mood and loss of interest or pleasure in normally enjoyable activities (American Psychiatric Association, 2013). Whereas most diagnostic criteria for depressive disorders and SAD are distinct, these disorders share significant conceptual overlap (Brown & Barlow, 1992), have high rates of comorbidity (Brown, Campbell, Lehman, Grisham, & Mancill, 2001), and are responsive to similar cognitive behavior therapy (CBT) treatments (Cuijpers et al., 2013; Norton & Price, 2007; Olatunji et al., 2010). As such, research is needed to identify both common and distinct cognitive vulnerabilities associated with depressive disorders and SAD to gain insight into the development and course as well as to inform the classification and treatment of these related psychiatric conditions.

1.1. A hierarchical model of cognitive vulnerability for depressive and anxiety disorders

Hierarchical models of cognitive vulnerabilities for depressive and anxiety disorders offer a potential framework for understanding shared and unique vulnerability for depressive disorders and SAD. Norton et al. (e.g., Norton, Sexton, Walker, & Norton, 2005; Paulus, Talkovsky, Heggeness, & Norton, 2015; Sexton, Norton, Walker, & Norton, 2003) have proposed one such model. This model posits that the influence of a higher-order vulnerability, negative affect (NA; considered

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conceptually equivalent to neuroticism; Barlow, Sauer-Zavala, Carl, Bullis, & Ellard, 2014; Ormel, Rosmalen, & Farmer, 2004), conceptualized as the predisposition to experience negative or aversive emotions (Norton & Mehta, 2007; Paulus et al., 2015) is partially accounted for/mediated by cognitive vulnerabilities. Norton et al. propose that high NA predisposes an individual to develop elevated intolerance of uncertainty (IU), defined as the incapacity to endure aversive sensations triggered by a perceived lack of certainty about current or future events (Carleton, 2016; Carleton et al., 2007). Norton et al. also posit that high NA predisposes an individual to anxiety sensitivity (AS), defined as the fear of catastrophic outcomes related to anxious arousal (Reiss & McNally, 1985). In turn, elevations in IU and AS predispose an individual to develop depressive and anxiety symptoms and disorders. Initial support for this model as a framework to understand social anxiety and depression involves numerous studies that have found that IU and AS are associated with depressive and social anxiety symptoms and disorders (Allan, Albanese, Short, Raines, & Schmidt, 2015; Boelen & Reijntjes, 2009; Carleton et al., 2012; Miranda et al., 2008; Olatunji & Wolitzky-Taylor, 2009; Riskind, Tzur, Williams, Mann, & Shahar, 2007; Taylor, Koch, Woody, & McLean, 1996).

Several studies have tested this proposed hierarchical model more specifically, including both depressive and social anxiety symptoms as outcomes (Norton & Mehta, 2007; Norton et al., 2005; Paulus et al., 2015). For example, in a sample of 650 undergraduate students, Norton and Mehta (2007) found that the relations between NA and self-reported social anxiety symptoms were partially explained via IU and AS, although IU accounted for 10% of the overlapping variance whereas AS accounted for only 2% of the overlapping variance between NA and social anxiety symptoms. The relation between NA and depression was partially explained by IU only, which accounted for 6% of the variance. Paulus et al. (2015) examined this hierarchical model in a sample of 642 clinical outpatients seeking services for depressive and anxiety disorders. Latent variables comprising self-reported and clinically assessed depressive and anxiety symptoms were treated as outcome variables. IU partially accounted for the relations between NA and both social anxiety and depression outcomes. Although the path from NA to depression through AS was not tested, an indirect path from NA to social anxiety through AS was not significant. Together, these findings suggest that IU, and not AS, accounts for the relations NA shares with social anxiety and depression.

An important limitation of this prior research is the lack of consideration for the structure of IU and AS. Both IU and AS are hierarchical constructs, with higher-order IU and AS composed of lower-order dimensions that are differentially related to depressive and social anxiety symptoms (but see Allan, Albanese et al., 2015, Allan, Macatee, Norr, Raines, & Schmidt (2015) and Hale et al., 2016 for alternate views of AS and IU, respectively, as primarily unidimensional). IU is composed of two lower-order dimensions, prospective and inhibitory IU (McEvoy & Mahoney, 2011). Prospective IU is future-oriented and emotion-focused (i.e., “Unforeseen events upset me greatly”). Inhibitory IU is present-oriented and behavior-focused (i.e., “When it’s time to act, uncertainty paralyses me”; Carleton et al., 2007). When prospective and inhibitory IU have been considered together, inhibitory IU was uniquely related to social anxiety and depressive disorder symptoms whereas prospective IU was not (Boelen, Reijntjes, & Smid, 2016; Carleton, Collimore, & Asmundson, 2010; McEvoy & Mahoney, 2012). This suggests that the indirect relations between NA and depressive and social anxiety symptoms are through inhibitory IU only. Therefore, if prospective IU is less related to these outcome variables, including a higher-order scale containing both dimensions may attenuate the indirect role of inhibitory IU between NA and depressive and social anxiety symptoms.

AS is composed of three lower-order dimensions: physical (fear of physiological symptoms of anxiety), cognitive (fear of losing control of mental processes), and social concerns (fear of outwardly observable anxiety; Taylor et al., 2007). Unlike the overlap in specific lower-order cognitive vulnerabilities found with IU, the lower-order dimensions of AS appear to be more specific in their relations with depressive and social anxiety symptoms. AS cognitive concerns is most strongly related to depression, when considering all the AS dimensions together (e.g., Allan, Capron, Raines, & Schmidt, 2014; Naragon-Gainey, 2010; Noel, Lewis, Francis, & Mezo, 2013; Norr, Allan, Macatee, Capron, & Schmidt, 2016). In contrast, AS social concerns is most strongly related to social anxiety (e.g., Allan et al., 2014; Allan, Albanese et al., 2015; Allan, Macatee et al., 2015; Naragon-Gainey, 2010). Therefore, whereas AS was not found to explain the relations between NA and depressive and social anxiety symptoms (e.g., Paulus et al., 2015), this might be due to focusing on the higher-order AS dimension instead of the lower-order AS dimensions.

Given prior findings indicating that the lower-order dimensions of IU and AS have differential relations with social anxiety and depression (e.g., Allan et al., 2014; Carleton et al., 2010), examining these lower-order dimensions may be particularly informative in parsing out the complex relation between NA, lower-order cognitive vulnerabilities, and depressive and social anxiety disorders. In the only study to date to consider the lower-order dimensions of AS and IU in relation to a hierarchical model of cognitive vulnerabilities, Allan, Oglesby, Uhl, and Schmidt (2016) examined the indirect relations between NA and social anxiety through AS and IU lower-order variables in an online community sample. The influence of NA on social anxiety was fully accounted for by inhibitory IU, AS social concerns, and fear of negative evaluation (FNE). Whereas these findings provide support for a more refined hierarchical model of risk for depressive and anxiety disorders, this study only examined social anxiety as an outcome variable and was conducted in a community sample. Therefore, it is important to extend these findings to a clinical sample that includes depression as an outcome to examine common and unique aspects of AS and IU as potential explanatory variables for the relation between NA and depressive and social anxiety symptoms.

1.2. The current study

The purpose of the current study is to expand upon a hierarchical model of cognitive vulnerabilities proposed by Norton et al. (Norton et al., 2005; Paulus et al., 2015) by focusing on the lower-order dimensions of IU and AS as potential indirect pathways from NA to social anxiety and depression. The indirect relation between NA and social anxiety and depressive symptoms and diagnostic status was examined in a community sample recruited to be at-risk for depressive and anxiety disorders. Clinical diagnoses were included as outcome variables to determine whether this model expanded to diagnostic status in addition to symptoms. The lower-order dimensions of AS and IU were considered to explain the relations between NA and social anxiety and depression. Based on the prior study by Allan et al. (2016), it was expected that AS social concerns and inhibitory IU would explain the relation between NA and social anxiety symptoms as well as SAD. Although no prior studies have examined the indirect relations between NA and depression through lower-order dimensions of AS and IU, prior research has demonstrated that the lower-order dimensions of AS cognitive concerns and inhibitory IU are most strongly related to depression (e.g., Allan et al., 2014; McEvoy & Mahoney, 2012). Therefore, it was expected that AS cognitive concerns and inhibitory IU would both explain the relation between NA and depressive symptoms as well as depression diagnoses.

2. Method

2.1. Participants

To participate in a randomized clinical trial examining the efficacy of a brief, computerized intervention targeting risk factors for

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