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ScienceDirect
Personality and Individual Differences 42 (2007) 345–354
PERSONALITY AND INDIVIDUAL DIFFERENCES
www.elsevier.com/locate/paid

Anxiety disorder specificity of anxiety sensitivity in a community sample of young women

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Received 6 March 2006; received in revised form 26 June 2006; accepted 6 July 2006
Available online 15 September 2006

Abstract

Anxiety sensitivity (AS) was originally proposed as a specific vulnerability factor for panic disorder and anxiety. The specificity of this relationship has been questioned because AS has also been found to be associated with depressive symptomatology. Data from the Dresden Study of Mental Health, which utilized a large community sample ($N = 1867$) of young German women, were used to investigate whether AS possesses specificity to anxiety-related psychopathology versus depression-related psychopathology when specific disorders were utilized as dependent variables. Participants completed a diagnostic interview as well as self-report measures of AS and neuroticism. Logistic regression analyses that statistically adjusted for neuroticism indicated that elevated AS had significant positive associations with several anxiety disorders, but was not significantly associated with major depressive disorder or dysthymia. These findings are generally consistent with those of previous studies that utilized self-reports of psychopathology and they support the hypothesis that AS is a specific vulnerability for panic and anxiety. However, when the lower-order components of AS were considered a more complex pattern of findings emerged, including significant positive associations between depression and both the Physical Concerns and Social Concerns components of AS.

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0191-8869/$ - see front matter
doi:10.1016/j.paid.2006.07.016

Keywords: Anxiety sensitivity; Anxiety disorders; Depressive disorders; Confirmatory factor analysis

0. Introduction

Anxiety sensitivity (AS) is an individual difference variable characterized by a fear of anxiety-related sensations arising from beliefs that these sensations have harmful consequences (Reiss, 1991). AS is conceptualized as being comprised of three inter-correlated lower-order components that load on a single higher-order AS factor (see Zinbarg, Mohlman, & Hong, 1999). The lower-order components are commonly referred to as Physical Concerns (e.g., fears of anxiety-related physical sensations such as a racing heart), Psychological Concerns (e.g., fears of cognitive symptoms of anxiety such as difficulty concentrating), and Social Concerns (e.g., fears of publicly-observable anxiety symptoms such as shaking).

AS has received extensive attention as a risk factor for panic disorder. The most convincing evidence that those with elevated levels of AS are at risk for developing panic disorder has come from longitudinal studies by Schmidt and colleagues (Schmidt, Lerew, & Jackson, 1997, 1999) that found baseline scores on the Anxiety Sensitivity Index (ASI; Peterson & Reiss, 1987) were predictive of the occurrence of subsequent panic attacks.

The relationships between AS and other disorders, particularly depression, have received growing attention. For example, Taylor, Koch, Woody, and McLean (1996) found that depressed patients had elevated scores on the ASI relative to published norms. As well, using a sample of patients with either panic disorder, major depression, or both of these disorders, they examined relationships between AS components and both mood and anxiety measures. Overall, the AS components related to Physical and Social Concerns tended to have significant positive associations with anxiety measures, but not with measures of depression. In contrast, the Psychological Concerns, or cognitive dyscontrol, component of AS was strongly associated with measures of depression severity, but not with measures of anxiety. Comparisons across the diagnostic groups (viz., panic disorder, major depression, or major depression and panic disorder) indicated that major depression was associated with the highest scores on the Psychological Concerns component.

Two issues regarding the specific causal relationships between AS and anxiety disorders have been raised. First, Lilienfeld, Turner, and Jacob (1993) suggested that the association between AS and panic may be due to shared variance between AS and trait anxiety. In order to address this possibility, measures of trait anxiety have been used to evaluate whether ASI scores account for unique variance in the outcome of interest beyond that accounted for by trait anxiety. For example, Schmidt et al. (1997) found that ASI scores contributed unique variance in predicting the development of spontaneous panic attacks beyond that accounted for by scores on a measure of trait anxiety. Second, Schmidt, Lerew, and Jackson (1999) noted that the associations between AS and depression described above may preclude AS from being a specific vulnerability for anxiety. To address this issue, they conducted a longitudinal study evaluating the ability of AS to predict subsequent symptoms of anxiety and depression. They utilized regression analyses that accounted for the covariation of changes in anxiety and changes in depression (i.e., controlling for changes in anxiety when examining changes in depression and vice versa). Their findings indicated that AS was uniquely associated with anxiety symptoms or possessed symptom specificity for anxiety.