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Differential Associations between Components of Anxiety Sensitivity and Smoking-Related Characteristics

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Abstract

Anxiety sensitivity (AS)—the tendency to fear anxiety-related experiences—is a risk factor for anxiety disorders and may contribute to smoking motivation and maintenance. Few studies have examined relations between conceptually distinct components of AS and smoking behavior. The purpose of the current study was to examine associations between AS components—Physical Concerns, Mental Concerns, and Social Concerns—and an array of smoking-related characteristics. In a cross-sectional design, we administered the Anxiety Sensitivity Index (ASI) and self-report measures of tobacco dependence, smoking abstinence behavior, and smoking outcome and abstinence expectancies to 314 smokers (10 cigarettes/day, 32% female, *M* age = 44 years). ASI Mental Concerns was most clearly associated with greater difficulty maintaining abstinence and stronger expectations of smoking-related negative reinforcement and withdrawal (β s = .21–.31, *ps* .005); ASI Social Concerns was most clearly associated with stronger positive reinforcement smoking expectancies (β = .20, *p* = .0009); and ASI Physical Concerns was most clearly associated with stronger tobacco withdrawal symptoms experienced in prior quit attempts (β = .20, *p* = .002). Based on these findings of patterns of associations with smoking-related characteristics across distinct components of AS, we speculate that: (1) mindfulness training may be useful for treating tobacco addiction in smokers high in ASI Mental Concerns; and (2) smokers high in ASI Physical and Social Concerns may benefit from smoking cessation treatment that

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incorporates interoceptive exposure and cognitive-behavioral therapy for social anxiety, respectively.

Keywords

anxiety sensitivity; smoking; tobacco dependence; withdrawal; relapse; expectancies

1. Introduction

Anxiety sensitivity (AS), or the tendency to fear anxiety-related experiences, is a dispositional cognitive characteristic implicated in the etiology of panic and other anxiety disorders.^[1-3] For instance, people high in AS tend to be fearful of harmless heart palpitations because they believe these sensations may lead to cardiac arrest, whereas people low in AS do not fear these sensations because they consider them to be benign. AS is distinct from anxiety and depressive symptoms^[4,5] and has been shown to prospectively predict the development or maintenance of anxiety symptoms, panic attacks, and certain anxiety and stress-related disorders (e.g., posttraumatic stress disorder).^[6-9]

A growing literature indicates that AS is related to numerous aspects of smoking, including greater perceived barriers to smoking cessation,^[10] greater odds of early smoking lapse^[11,12] and relapse,^[5,11,13] and more intense tobacco withdrawal symptoms.^[14,15] Most prior smoking-oriented work has focused on AS a single dimension. However, factor analyses of the Anxiety Sensitivity Index (ASI, the most common measure of AS)^[3] have revealed three lowerorder factors: physical concerns (fear of the implications of anxiety-related physical symptoms), mental concerns (fear that anxiety and concentration problems may indicate abnormal mental functioning), and social concerns (fear that others may notice anxiety symptoms).^[2,16]

Presently, however, there is little empirical work exploring AS lower-order dimensions and smoking behavior. In one cross-sectional study of non-treatment-seeking daily smokers, ASI Physical Concerns and Mental Concerns were related to greater expectations that smoking alleviates aversive states (i.e., greater negative reinforcement smoking outcome expectancies), but no subscale was related to tobacco dependence severity or expectations that smoking results in rewarding effects (i.e., greater positive reinforcement smoking outcome expectancies).^[17] A few other cross-sectional investigations of non-treatment-seeking daily smokers have found that ASI Physical Concerns is related to shorter abstinence duration when controlling for other ASI subscales.^[13,18] It is important to extend such findings to other smoking-related characteristics, including subtypes of tobacco dependence, other forms of smoking outcome expectancies (e.g., beliefs that smoking helps regulate weight), smoking abstinence expectancies (i.e., beliefs about what would occur if one would quit smoking), and tobacco withdrawal symptoms. Such information could help inform smoking cessation treatments tailored to high-AS smokers who have different fears regarding anxiety-related experiences.

The present study examined relations between ASI subscales and an array of smokingrelated characteristics among daily cigarette smokers. In theory, individuals higher in ASI Physical

Concerns may be prone to smoke because they believe smoking will minimize aversive physical sensations associated with hunger and tobacco withdrawal, such as cough and dizziness^[19,20] (related to negative reinforcement). Individuals higher in ASI Mental Concerns may be prone to smoke because they believe smoking will improve their mood and concentration, including anxiety and concentration difficulties experienced during tobacco withdrawal^[19,20] (related to negative reinforcement). Individuals higher in ASI Social Concerns may be prone to smoke because they believe it will enhance their comfort in social situations^[21,22] (related to positive reinforcement). Therefore we hypothesized that: (1) ASI Physical and Mental Concerns will be associated with greater negative reinforcement smoking expectancies, withdrawal symptoms and expectancies, and difficulty maintaining abstinence from smoking; (2) ASI Social Concerns will be associated with stronger positive reinforcement smoking expectancies; and (3) ASI Physical Concerns will be associated with stronger smoking expectancies related to appetite/weight. We had no hypotheses regarding associations with tobacco dependence.

2. Methods

2.1 Participants

Participants were 314 smokers (32% female; M age = 44.0, SD = 10.8), of whom 54.1% were Black, 32.8% were White, and 13.1% were of another racial background. The large majority of participants (81.7%) belonged to a household with a yearly income of less than \$30,000. On average, participants displayed a moderate level of tobacco dependence on the Fagerström Test of Nicotine Dependence^[23] (M = 5.4, SD = 2.0), reported regularly smoking for 25 years (SD = 11.5), and were currently smoking 16.5 cigarettes per day (SD = 7.0).

The current report reflects a secondary analysis of baseline data from a multi-session laboratory study of smoking abstinence effects. Between January 2010 and November 2012, participants were recruited from the Los Angeles area via online advertisements and fliers announcing the opportunity to take part in a study on personality and smoking. Inclusion criteria required participants to be fluent in English, 18+ years of age, and a regular smoker of 10+ cigarettes per day during the past 2+ years. Exclusion criteria included breath carbon monoxide (CO) levels < 10 ppm at intake, regular cigar use, planning to quit or substantially reduce smoking in the next 30 days, psychiatric medication use, and current *DSM-IV* non-nicotine substance dependence, mood disorder, or psychotic symptoms (the latter two of which were included so as not to adversely interact with smoking abstinence effects in the larger study).

Of the 505 smokers recruited, 29 had missing data, 7 declined to participate, and 155 were ineligible (57% due to low CO levels, 20% due to *DSM-IV* diagnoses, 15% due to planning to quit or reduce smoking, 5% due to regular cigar use, and 3% due to psychiatric drug use), leaving a total sample of 314 participants. Smoking History Questionnaire data regarding withdrawal symptoms and quit attempts were available for 295 and 232 participants because participants answered those questions only if they had ever tried to stop smoking and if they had ever made a serious and deliberate quit attempt, respectively. Also, data from the Smoking Abstinence Questionnaire was available for 197 participants because that measure

was introduced midstream into recruitment. Participants were paid \$15 to complete the baseline session. The University of Southern California Institutional Review Board approved the protocol.

2.2 Measures

2.2.1 Anxiety Sensitivity (AS)—The Anxiety Sensitivity Index (ASI)^[3] is a self-report measure that evaluates fearfulness of anxiety-related experiences on a scale of 0-64. The ASI (Total Scale: 16 items) is composed of three subscales: Physical Concerns (8 items; e.g., “It scares me when I feel shaky”), Mental Concerns (4 items; e.g., “When I cannot keep my mind on a task, I worry that I might be going crazy”), and Social Concerns (4 items; e.g., “It is important not to appear nervous”).^[2,16]

2.2.2 Severity of Tobacco Dependence—The Fagerström Test of Nicotine Dependence (FTND)^[24] is a 6-item self-report measure that assesses tobacco dependence severity on a scale of 0-10. The FTND has consistently been separated into two factors: morning smoking (items 3 and 5) and daytime smoking (items 2, 4, and 6).^[25]

2.2.3 Smoking Abstinence Expectancies—The Smoking Abstinence Questionnaire (SAQ)^[26] was used to assess the extent to which an individual expects to experience certain consequences after quitting smoking, including withdrawal symptoms (7 items) and weight gain (3 items). Items are rated on a 7-point Likert scale ranging from 0 (*not likely at all*) to 6 (*extremely likely*).

2.2.4 Smoking Outcome Expectancies—The Smoking Consequences Questionnaire (SCQ)^[27] was used to assess the extent to which an individual expects smoking to lead to positive reinforcement/sensory satisfaction (15 items), negative reinforcement/negative affect reduction (12 items), and appetite-weight control (5 items). Items are rated on a 7-point Likert scale ranging from 1 (*not true of me at all*) to 7 (*very true of me*).

2.2.5 Smoking Abstinence Behavior—The Smoking History Questionnaire (SHQ) is an author-constructed questionnaire that was used to assess duration of abstinence during past quit attempts (from which we determined proportion of quit attempts that lasted less than one week) and severity of withdrawal symptoms during the most recent quit attempt on a scale of 7-35. The SHQ Withdrawal Symptoms scale is composed of 7 items pertaining to commonly endorsed symptoms of tobacco withdrawal,^[20] including cravings, irritability, nervousness, difficulty concentrating, physical symptoms, difficulty sleeping, and loss of interest or pleasure. In the current study, scores on the SHQ Withdrawal Symptoms scale were strongly correlated ($r = .40$) with severity of tobacco dependence as measured by the FTND, which attests to the convergent validity of the scale.

2.2.6 Demographic and Smoking-Related Characteristics—An author-constructed questionnaire was used to assess demographic (gender, age, and race) and smoking-related characteristics (age of onset and years of regular smoking and cigarettes smoked per day).

2.2.7 Anxiety Symptoms—The Mood and Anxiety Symptom Questionnaire Anxious Arousal Scale (MASQ-AA)^[28] is a 17-item self-report measure that was used to assess the severity of anxiety symptoms experienced during the past week on a scale of 17-85.

2.3 Procedure

Subsequent to passing the phone screen, participants attended a baseline session involving informed consent, breath CO analysis, and administration of the Structured Clinical Interview for *DSM-IV* Non-Patient Edition^[29] to assess eligibility criteria. Eligible participants continued with the remainder of the baseline session and completed all measures in paper format.

2.4 Data Analysis

We first examined correlations between AS and demographic and smoking-related characteristics and obtained descriptive statistics and Cronbach's alphas (when applicable) for all key variables. We then ran linear regression models adjusting for covariates in which one measure of AS served as the predictor variable and one smoking measure served as the criterion variable. MASQ-AA was included as a planned covariate in all regression models in order to examine the predictive validity of AS measures on criterion variables beyond that of shared variance with anxiety symptoms. Demographic or smoking-related characteristics that were significantly correlated with any measure of AS together with any of the criterion variables were also entered as covariates. For individual regression models, we also used a Holm-Bonferonni correction for multiple tests^[30] to control for the overall error rate within each family of criterion variables: tobacco dependence (FTND Total Scale, Morning Smoking, and Daytime Smoking), retrospectively reported smoking abstinence behavior (SHQ Withdrawal Symptoms and proportion of quit attempts that lasted less than one week), and smoking expectancies (SCQ Appetite-Weight Control and Positive and Negative Reinforcement and SAQ Withdrawal and Weight Gain). For smoking measures in uncorrected individual models that were significantly associated with any of the ASI subscales, we included all three subscales as simultaneous predictors in order to determine if subscales were associated with smoking measures beyond that of shared variance with other subscales. Findings significant at an unadjusted alpha level of .05 are reported, as this was the first study to examine AS components in relation to many of these smoking measures. Results are reported as standardized regression coefficients (β s).

3. Results

3.1 Preliminary Analyses

Race (non-Black coded as 0 and Black coded as 1) was significantly correlated with all four measures of AS ($r_{pb} = .16, p = .004$ for each measure) and was also significantly correlated with FTND Morning Smoking ($r_{pb} = .18, p = .001$) and SAQ Weight Gain ($r_{pb} = .20, p = .005$). Therefore, all regression models controlled for race as well as for the planned covariate of anxiety symptoms. Descriptive statistics and Cronbach's alphas for anxiety sensitivity and smoking measures are displayed in Table 1.

3.2 Primary Analyses

As displayed in Table 2, individual regression models showed that all four AS measures were significantly associated with higher SCQ Positive and Negative Reinforcement, SAQ Withdrawal, and SHQ Withdrawal Symptoms scores. ASI Total Scale and Physical Concerns were also significantly associated with higher SAQ Weight Gain scores. ASI Mental Concerns was also significantly associated with higher FTND Daytime Smoking and SAQ Weight Gain scores and a greater (SHQ) proportion of quit attempts that lasted less than one week. None of the AS measures were significantly associated with SCQ Appetite-Weight Control or FTND Total Scale or Morning Smoking scores.

After applying Holm-Bonferroni corrections, all four AS measures were still significantly associated with higher SCQ Negative Reinforcement scores. ASI Total Scale was also still significantly associated with higher SHQ Withdrawal Symptoms, SCQ Positive Reinforcement, and SAQ Withdrawal scores. ASI Physical Concerns was also still significantly associated with higher SHQ Withdrawal Symptoms scores. ASI Mental Concerns was also still significantly associated with a greater proportion of quit attempts that lasted less than one week and higher SHQ Withdrawal Symptoms, SCQ Negative Reinforcement, and SAQ Withdrawal scores. ASI Social Concerns was also still significantly associated with higher SCQ Positive Reinforcement scores. Effect sizes (sr^2) for individual predictors that retained significance ranged from .02 to .08 (small to medium in magnitude^[31]).

3.3 Supplemental Analyses

In combined models involving all three ASI subscales as simultaneous predictors, only ASI Mental Concerns was significantly associated with FTND Daytime Smoking ($\beta = .19$, $SE = .09$, $p = .030$); both ASI Mental Concerns ($\beta = .29$, $SE = .10$, $p = .003$) and ASI Social Concerns ($\beta = -.17$, $SE = .08$, $p = .030$) were associated with proportion of quit attempts that lasted less than one week; only ASI Social Concerns was significantly associated with SCQ Positive Reinforcement ($\beta = .15$, $SE = .07$, $p = .023$); both ASI Mental Concerns ($\beta = .22$, $SE = .08$, $p = .006$) and ASI Social Concerns ($\beta = .13$, $SE = .06$, $p = .043$) were significantly associated with SCQ Negative Reinforcement; only ASI Mental Concerns was significantly associated with SAQ Withdrawal ($\beta = .29$, $SE = .10$, $p = .004$); and none of the subscales were significantly associated with SHQ Withdrawal Symptoms or SAQ Weight Gain.

3.4 Unplanned Analyses

Because race was correlated with all three ASI subscales and with FTND Morning Smoking and SAQ Weight Gain, we examined if race moderated ASI subscale relations with those two measures by using the ASI subscale that was most strongly associated with FTND Morning Smoking and SAQ Weight Gain in primary analyses. Using PROCESS for SPSS,^[32] moderated regression analyses revealed that the interaction of ASI Social Concerns and race on FTND Morning Smoking was not significant ($p = .11$), whereas the interaction of ASI Mental Concerns and race on SAQ Weight Gain was significant ($\beta = -.13$, $SE = .06$, $p = .04$), indicating that ASI Mental Concerns was positively associated with SAQ Weight Gain to a greater degree in non-Black participants relative to Black participants.

4. Discussion

Consistent with our hypotheses, ASI Mental Concerns was associated with greater withdrawal symptoms and expectancies, difficulty maintaining abstinence, and expectations of negative reinforcement from smoking. In addition, combined models indicated that ASI Mental Concerns is associated with greater difficulty maintaining abstinence and stronger expectations of smoking-related negative reinforcement and withdrawal incrementally to other ASI subscales. These data, consistent with past work,^[17,33,34] suggest that smokers high in ASI Mental Concerns may be especially prone to continue smoking as a form of negative reinforcement. Yet, these results are inconsistent with past research indicating that only ASI Physical Concerns is related to shorter abstinence duration incrementally to other ASI subscales.^[13,18] However, these past studies used samples that differed in size (N s 130 vs. $N = 314$ in the current study), race/nationality (Mexican or mostly White smokers vs. mostly African-American smokers in the current study), average age ($M = 30$ years vs. $M = 44$ years in the current study), and average duration of regular smoking ($M = 5$ -13 years vs. $M = 25$ years in the current study).

Partially consistent with our hypotheses, ASI Social Concerns was associated with stronger positive and negative reinforcement smoking expectancies incrementally to other ASI subscales. These findings are in contrast to two prior studies that reported no relation between ASI Social Concerns and positive or negative reinforcement smoking motives or expectancies.^[17,33] Notably, however, those two prior studies used smaller, largely White samples ($N = 90$ -119). Regarding SCQ Positive Reinforcement, it is worth noting that two items reference smoking-related social interaction, and it makes sense that obtaining sensory satisfaction from smoking would lend itself to socialization. Furthermore, a closer examination of the four ASI Social Concerns items reveals that half of them are related to emotional control, which may help to explain why smokers high in ASI Social Concerns expect greater negative affect relief (emotional control) from smoking. Combined models also indicated that ASI Social Concerns was associated with a lower proportion of quit attempts that lasted less than one week, which concords with a prior study that found ASI Social Concerns was incrementally associated with a lower occurrence of early smoking relapse.^[13] It may be that smokers high in ASI Social Concerns tend not to display early relapse because they fear being negatively evaluated by others.^[35]

Partially consistent with our hypotheses, ASI Physical Concerns was associated with greater levels of withdrawal symptoms and negative reinforcement smoking expectancies but not with difficulty maintaining abstinence or smoking expectancies related to appetite/weight or withdrawal. The association between ASI Physical Concerns and negative reinforcement smoking expectancies is consistent with past research.^[17,33,34] This is the first study to report a relationship between ASI Physical Concerns and severity of tobacco withdrawal symptoms, which is consistent with the notion that smokers high in ASI Physical Concerns may be especially affected by withdrawal-related bodily sensations.^[13,18] Surprisingly though, ASI Physical Concerns was not related to tobacco withdrawal symptom severity or negative reinforcement smoking expectancies incrementally to other ASI subscales, which may reflect that tobacco-related negative reinforcement and withdrawal symptoms are primarily tied to negative affective (emotional) states.^[19,27]

None of the ASI subscales were related to severity of tobacco dependence as measured by the FTND, which is consistent with past research,^[17] and none of the ASI-subscale relations with FTND factor scores survived correction for multiple testing.

Interestingly, race was correlated with all four measures of AS, such that Black smokers displayed higher AS levels than non-Black (mostly White) smokers (for descriptive purposes, ASI Total Scale: *M* score for Black smokers = 23.0 vs. *M* score for non-Black smokers = 17.5). This contrasts with two prior studies that found similar levels of AS among African-American and European-American undergraduates.^[36,37] One could speculate that AS is a more important determinant of smoker status in African Americans relative to European Americans, thus explaining why ASI scores were higher for Black vs. mostly White smokers but not for Black vs. White undergraduates. If that is the case, then treatments that reduce AS may be more beneficial to smoking cessation in African Americans. However, current findings would need to be replicated before race can be identified as a clear correlate of AS in smokers. Also, exploratory analyses revealed that ASI Mental Concerns was positively associated with expectations that smoking abstinence will lead to weight gain to a greater degree in non-Black participants relative to Black participants. Overall, these findings highlight the need for further research into potential racial differences in AS and AS-smoking relations.

4.1 Limitations

The current study has limitations. Because it is cross-sectional, it cannot examine changes over time or determine causality. Also, exclusion criteria included non-nicotine substance dependence and current mood disorder, which limits the generalizability of current results in relation to smokers with psychiatric comorbidities. In addition, the current study only examined associations between self-report measures, which may be influenced by common-method bias, and SHQ measures involved the retrospective reporting of withdrawal symptom severity and abstinence duration, which may have been influenced by inaccurate memory. Also in regard to the SHQ, the questionnaire does not cover all common symptoms of tobacco withdrawal (e.g., sadness and increased appetite) and has not gone through a thorough assessment of reliability and validity, although we have provided some initial evidence in support of the measure's reliability (satisfactory Cronbach's alpha) and convergent validity (highly correlated with the FTND). Lastly, the internal consistency coefficients of FTND measures and the ASI Social Concerns subscale were all quite low. Although this is concordant with prior studies using these measures,^[2,25] such low estimates of reliability may have contributed to the discrepant findings across studies that examined ASI Social Concerns in relation to smoking variables. Future AS component studies would benefit from using the ASI-3, which has displayed improved reliability compared to the original ASI, particularly in regard to the social concerns facet of AS.^[38]

4.2 Conclusions

Current results expand the literature on AS-smoking relations and suggest that certain approaches may be helpful in treating subgroups of high-AS smokers who desire to quit smoking. ASI Mental Concerns was associated with several indicators of smoking motivation and maintenance, especially those related to negative reinforcement. Thus, one

intervention that may be effective in treating smokers high in ASI Mental Concerns is mindfulness training,^[39] which encourages individuals to focus on and accept aversive mental states rather than react to them (e.g., rather than reacting to negative affect by smoking). ASI Social Concerns was associated with both positive and negative reinforcement smoking expectancies, and there was some indication that smoking in individuals high in ASI Social Concerns is guided by a desire for enhanced social comfort and emotional control, particularly in regard to not wanting to appear nervous or be negatively evaluated, similar to social anxiety disorder. Accordingly, techniques from cognitive-behavioral therapy for social anxiety disorder^[40] may be a useful addition to smoking cessation treatment for smokers high in ASI Social Concerns, such as exposure to feared social situations, cognitive restructuring of negative beliefs about social situations, relaxation training, and social skills training. ASI Physical Concerns was associated with negative reinforcement smoking expectancies and severity of tobacco withdrawal symptoms. Hence, interoceptive exposure^[41] may assist with smoking cessation treatment for smokers high in ASI Physical Concerns, which involves exposing smokers to increasing levels of anxiety-related bodily sensations and incrementally longer periods of smoking deprivation.

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Highlights

- We studied anxiety sensitivity (AS) components in relation to smoking measures.
- AS mental concerns was related to several negative reinforcement-related measures.
- AS social concerns was associated with positive reinforcement smoking expectancies.
- AS physical concerns was most clearly associated with nicotine withdrawal symptoms.
- It may be useful to tailor treatment approaches to subgroups of high-AS smokers.

Table 1
Descriptive Statistics and Cronbach's Alphas for Anxiety Sensitivity and Smoking Measures

	<i>M (SD)</i>	Cronbach's α
ASI Total Scale	20.5 (13.1)	.91
ASI Physical Concerns	10.0 (8.3)	.90
ASI Mental Concerns	2.8 (3.5)	.83
ASI Social Concerns	7.6 (3.0)	.48
FTND	5.4 (2.0)	.59
Factor 1: Morning Smoking	1.1 (0.8)	.39
Factor 2: Daytime Smoking	2.0 (1.2)	.52
SHQ % Quit Attempts < 1 week abstinent	53.8 (41.2)	
SHQ Withdrawal Symptoms	17.7 (6.4)	.89
SCQ Positive Reinforcement	67.7 (18.1)	.88
SCQ Negative Reinforcement	51.4 (20.7)	.96
SCQ Appetite-Weight Control	15.0 (10.2)	.96
SAQ Withdrawal	26.3 (9.8)	.87
SAQ Weight Gain	9.6 (5.6)	.86

Note. ASI = Anxiety Sensitivity Index; FTND = Fagerström Test of Nicotine Dependence; SHQ = Smoking History Questionnaire; SCQ = Smoking Consequences Questionnaire; SAQ = Smoking Abstinence Questionnaire.

Table 2
Individual Regression Models between Anxiety Sensitivity and Smoking Measures
Expressed as β (SE)

Measure	ASI Total Scale	ASI Physical Concerns	ASI Mental Concerns	ASI Social Concerns
<i>Tobacco Dependence</i>				
FTND	.07 (.06)	.08 (.06)	.12 (.06)	-.07 (.06)
Factor 1: Morning Smoking	.02 (.06)	.03 (.06)	.07 (.06)	-.08 (.06)
Factor 2: Daytime Smoking	.10 (.06)	.08 (.06)	.15 (.06)*	.00 (.06)
<i>Smoking Abstinence Behavior</i>				
SHQ % QA < 1 week abstinent	.11 (.08)	.10 (.07)	.21 (.08)**	-.06 (.07)
SHQ Withdrawal Symptoms	.21 (.06)**	.20 (.06)**	.17 (.06)**	.12 (.06)*
<i>Smoking Expectancies</i>				
SCQ Positive Reinforcement	.20 (.06)**	.14 (.06)*	.18 (.06)**	.20 (.06)***
SCQ Negative Reinforcement	.31 (.06)***	.25 (.06)****	.31 (.06)****	.24 (.06)****
SCQ Appetite-Weight Control	.12 (.06)	.10 (.06)	.11 (.06)	.06 (.06)
SAQ Withdrawal	.23 (.07)**	.18 (.07)*	.28 (.07)***	.18 (.07)**
SAQ Weight Gain	.15 (.07)*	.15 (.07)*	.16 (.07)*	.05 (.07)

Note. Individual regression models involve one measure of anxiety sensitivity as the predictor of each smoking measure adjusted for race and anxiety symptoms. Associations that survived Holm-Bonferroni correction are displayed in bold print. FTND = Fagerström Test of Nicotine Dependence ($N = 314$); SHQ = Smoking History Questionnaire ($N = 232$ and 295 , respectively); SCQ = Smoking Consequences Questionnaire ($N = 314$); Smoking Abstinence Questionnaire ($N = 197$).

*
 $p < .05$

**
 $p < .01$

 $p < .001$

 $p < .0001$