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Interactive Effects of Anxiety Sensitivity and Subjective Social Status on Psychological Symptomatology in Black Adults

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Abstract

Anxiety sensitivity is the fear of anxiety-related sensations and subjective social status is a self-perception of social standing relative to others: both constructs have been linked to psychological symptomatology. This study investigated the interactive effects of anxiety sensitivity and social status in relation to anxiety and depressive symptomatology expression among 124 Black adults. Participants provided sociodemographics and completed self-report questionnaires. The interactive associations between anxiety sensitivity and social status on anxiety symptomatology and depressive symptomatology were examined with hierarchical linear regressions adjusted for sociodemographics and negative affectivity. Significant interactions between anxiety sensitivity and social status were evident only for anxiety symptoms: specifically, the association between anxiety sensitivity and anxiety symptoms was much stronger for individuals with lower (versus higher) subjective social status. Black adults with this higher anxiety sensitivity/lower social status phenotype may be at heightened risk for the expression of anxiety symptomatology, and may benefit from interventions to reduce anxiety sensitivity.

Keywords

Anxiety sensitivity; anxiety symptoms; depressive symptoms; social status; Black ethnicity

INTRODUCTION

Anxiety sensitivity is a transdiagnostic individual difference factor, reflecting fear about the negative consequences of anxiety and bodily states.^{1–3} Specifically, anxiety sensitivity is characterized by amplified fear of behaviors or sensations associated with the experience of anxiety-related symptomatology.^{1–3} For example, physical manifestations of anxiety such as increased heart rate, dizziness, and sweating may be perceived by someone with elevated anxiety sensitivity as dangerous, harmful and potentially catastrophic (e.g., an impending heart attack or signal of mental collapse).^{1–3} Anxiety sensitivity is distinct from anxiety symptoms and negative mood more generally, and its etiology may lie in a combination of genetic diatheses and learned experience linking autonomic arousal in response to environmental stressors with an exaggerated perception of harm, danger, and vulnerability.⁴

An extensive literature, conducted largely among White samples, indicates that anxiety sensitivity is a risk factor for the development and maintenance of anxiety and depressive symptomatology and disorders.^{4–11} The limited work to date on anxiety sensitivity in Black adults,^{12,13} however, suggests that they may be more likely to attend to bodily sensations associated with anxiety symptomatology relative to Whites.¹³ Moreover, there is some evidence that the latent structure of anxiety sensitivity may differ between Black and White adults, with the former characterized by more physically-focused manifestations of anxiety sensitivity.¹² Other work among Black college students, however, suggests only modest associations of anxiety sensitivity with depressive and anxious symptomatology.¹⁴ To our knowledge, work exploring associations of anxiety sensitivity and psychological symptomatology has not been extended to more diversely-aged samples of Black adults. However, such work is of interest due to later onset of psychopathology among Black adults relative to White adults.¹⁵

Psychological symptom expression may also be influenced by social determinants of health, or the social and socioeconomic conditions within which individuals live. In particular, subjective social status (SSS) is a social determinant that is influenced by both social and socioeconomic factors.^{16–18} SSS is commonly measured using two ladders; the United States (U.S.; SSS-U.S.) and the community (SSS-community) versions of the MacArthur Scale of SSS.¹⁹ Specifically, individuals are presented with a picture of a ladder and are asked to rank themselves relative to others. The SSS-U.S. ladder assesses how individuals perceive themselves on a scale of 1 (bottom of ladder) to 10 (top of ladder) compared to others in the U.S. based on factors such as income and education, whereas the SSS-Community ladder assesses how individuals perceive themselves on the same ranked scale relative to others in their self-defined communities without reference to socioeconomic status. Lower SSS, on both ladders, has been associated with greater psychological symptomatology across multiple studies even after accounting for the influence of other traditional socioeconomic status factors such as education and employment status.^{18,20–25}

The two SSS ladders tend to be correlated with one another, but respondents appear to consider different factors when self-ranking. For example, studies tend to support stronger ties between the objective socioeconomic factors and the SSS-U.S. ladder rankings relative to the SSS-Community ladder rankings,^{17,19,26} and highlight the relevance of altruism and

community service in SSS-Community ladder rankings relative to SSS-U.S. ladder rankings.¹⁹ The SSS ladder developers suggest that the SSS-Community ladder may be particularly relevant for use among lower socioeconomic status groups because it may better capture social standing variations reflective of community roles, and therefore recommend the use of both ladders in health-related research.¹⁹ Further understanding the relative associations of these ladders with psychological symptomatology among Black adults, who on average are of lower socioeconomic status relative to Whites,²⁷ may be important to expanding understanding of how different dimensions of social standing affect mental health symptomatology in this racial/ethnic subgroup.

Research suggests that both SSS ladders may demonstrate incremental associations with psychological symptomatology over traditional socioeconomic indicators because they represent a relatively more nuanced social determinant that captures the potential for future status change, the quality of education, the prestige associated with a particular workplace, and job control.^{18,21,23,28} These unique components of SSS may also incrementally affect the expression of psychological symptoms.²⁹ They may also be particularly relevant to racial/ethnic minority groups like Black adults who may experience discrimination and other societal inequities and inequalities that can affect perceived social standing. Moreover, some research supports racial/ethnic differences in how strongly socioeconomic factors are associated with SSS,^{23,30} and in the strength of associations between SSS determinants and health-related outcomes.^{23,30,31} For example, research suggests that traditional socioeconomic factors like income are less strongly associated with SSS among Black than White adults,²³ perhaps because the former do not benefit equally to the latter under the same objective socioeconomic constraints. On the other hand, research suggests that SSS is more closely linked to depression and hypertension among White than Black men and women, although associations between SSS and depression are significant within both racial/ethnic groups.²³

Although evidence suggests that both anxiety sensitivity and SSS may confer risk for psychological symptomatology, the interaction between these factors might yield enhanced symptom expression. Specifically, low SSS may reduce the ability to cope with objective environmental stressors, and thereby increase in the intensity of psychological symptomatology and distress experienced in response to them.²¹ Indeed, a recent study conducted among Spanish-speaking Latino primary care patients found that individuals endorsing low SSS and high anxiety sensitivity reported the most mood and anxiety disorder diagnoses and the greatest panic, social anxiety, and depressive symptoms.³² The potential for SSS and anxiety sensitivity to interact in their association with psychological symptomatology expression among a Black community sample has not previously been investigated. Similar to Latinos, Black adults may also experience greater environmental and social stressors (e.g., poverty,²⁷ discrimination³³) relative to Whites, which can enhance psychological distress, strain coping resources, and convey vulnerability to the experience of psychological symptomatology.

The purpose of the present study was to examine the interactive effects of anxiety sensitivity and SSS-U.S. and SSS-Community on anxiety and depressive symptom expression among a community sample of diversely-aged Black adults. Based on prior research with Latino

adults,³² it was hypothesized that higher anxiety sensitivity co-occurring with lower SSS would be associated with greater degrees of psychological symptomatology, even after accounting for characteristic tendencies to experience negative moods (i.e., negative affectivity) and the influence of other social determinants of health, including traditional socioeconomic indicators.

METHODS

Participants and Procedures

Participants were adults recruited from a predominately Black church in Houston, Texas, that has over 17,000 members. This site was selected based on a successful multi-year partnership with church leadership and parishioners within which several previous studies have been conducted.^{34–39} Recruitment into the current study was accomplished via email solicitation of previous study participants. The email announcement described a study focused on stress and health behaviors among Black adults and included study contact information. Participation was not limited to the email recipients and directions indicated that the recruitment materials could be forwarded to friends and colleagues. Interested individuals were provided more information about the study and screened for eligibility by phone. Individuals were eligible to participate if: 1) they were 18 years old; 2) of self-reported Black ethnicity; 3) could provide valid contact information; and 4) were willing to comply with the study protocol.

Enrollment was limited to 124 participants based on a priori power calculations for the primary study aims. Individuals were screened and enrolled into the study in the order within which they contacted the study team. Data collection was completed on-site at the church. Following informed consent, participants completed study measures, which were administered on a laptop computer whereby participants entered responses using the keyboard. The full study protocol entailed two study visits and the collection of saliva samples in between visits; however, only data from the initial visit were relevant to addressing the study aim reported herein. Participants were compensated \$25 via a department store gift card during the first visit, and up to \$75 in department store gift cards at second visit (the latter based on compliance with the saliva sample collection). Data collection spanned December 2013 to February 2014. Study procedures were approved by the Institutional Review Boards at the primary institution (University of Houston) and collaborating institution (University of Texas MD Anderson Cancer Center).

Measures

Sociodemographics—Self-reported sociodemographic data included sex, age, partner status (single/widowed/divorced vs. married/living with partner), educational level (<Bachelor's degree vs. Bachelor's degree), and employment status (employed full time vs. part-time employed, disabled, homemaker, student, retired).

Anxiety Sensitivity—The 18-item Anxiety Sensitivity Index III (ASI) was designed to measure sensitivity to and discomfort with physical sensations.⁴⁰ Respondents rate their level of agreement with items including: “It scares me when I feel faint,” “When I am

nervous, I worry that I might be mentally ill,” and “Other people notice when I feel shaky.” Higher scores overall are indicative of greater anxiety sensitivity. The Cronbach’s alpha for the ASI in this sample was .95.

Subjective Social Status (SSS)—SSS was measured with the U.S. and Community versions of the MacArthur Scale of Subjective Social Status.¹⁹ The SSS-U.S. ladder has participants self-rank on a 10-rung pictorial ladder where they stand relative to others in the U.S., with higher rungs indicating higher status (i.e., more money, more education, and better jobs). The SSS-Community ladder has participants similarly self-rank subjective social status but with the referent of their self-defined communities. The SSS-Community ladder was administered prior to the SSS-U.S. ladder in this study, as recommended. The correlation between the SSS-U.S. ladder and the SSS-Community ladder in this sample was .62 ($p = .01$).

Anxiety Symptoms—The 21-item Beck Anxiety Inventory (BAI) was designed to assess common symptoms of anxiety (e.g., numbness and tingling, fear, abdominal discomfort, dizziness) experienced over the last week.⁴¹ Higher scores are associated with greater anxiety symptoms. The Cronbach’s alpha for the BAI in this sample was .95.

Depressive Symptoms—The 20-item Center for Epidemiologic Studies Depression scale (CESD) was developed to assess depressive symptoms (e.g., restless sleep, poor appetite, feeling blue) over the last week in community, non-clinical populations.⁴² Higher scores are associated with greater depressive symptoms. The Cronbach’s alpha for the CESD in this sample was .93.

Negative Affectivity—The negative affect (NA) subscale of the Positive and Negative Affect Schedule (PANAS) was designed to measure general dimensions of negative affectivity (e.g., irritability, shame, nervousness) over the previous week⁴³ and, based on previous research, was used as a covariate in the current study.³² Higher scores on this scale are indicative of greater NA. The Cronbach’s alpha for the PANAS NA in this sample was .90.

Data Analysis

Participant characteristics were examined using descriptive statistics, and correlations between study variables were assessed. The interactive associations between AS and each SSS ladder on the BAI total (anxiety symptomatology) and the CESD (depressive symptomatology) were examined respectively using hierarchical linear regressions. Each analysis had 3 steps. In Step 1, the covariates of sex, age, partner status, education, employment status, and NA were entered in the model. In Step 2, AS and SSS was entered. In Step 3, the interaction term between AS and SSS was added. Continuous variables were grand mean-centered. Analyses were performed in SPSS, version 19 (IBM, NY). Interaction results were graphed separately by those with lower and higher SSS using parameter estimates from the regression equation where high and low values were specified as one standard deviation above and below respective means.⁴⁴ Interactions were also probed for statistical significance transition points using the Johnson-Neyman technique. This approach

indicates the precise range of values on a continuous moderator variable within which the simple regression slope for the focal predictor (i.e., regression of x on y) is significantly different from zero, and which has advantages in accuracy and specificity over the pick-a-point approach.^{45–46}

RESULTS

Participants ($N = 124$; 79% female) were 49.02 years old on average (± 11.47 , range = 19–75 years) and almost half of the sample (48.4%) had at least a Bachelor's degree. Anxiety sensitivity was positively and subjective social status was negatively correlated with each of the criterion variables. Anxiety sensitivity, however, was not correlated with subjective social status. See Table 1 for participant characteristics and correlations between study variables.

With regard to anxiety symptomatology, covariates entered at Step 1 accounted for a significant amount of variance ($R^2 = .417$, $F(6, 117) = 13.964$, $p < .001$) and sex, employment status, and negative affectivity were significant predictors. At Step 2, both AS and SSS-US were significant predictors, and the variance accounted for ($R^2 = .644$, $F(8, 115) = 26.051$, $p < .001$) increased significantly. At Step 3, the interaction term between AS and SSS-US was significant, and the variance accounted for ($R^2 = .698$, $F(9, 114) = 29.259$, $p < .001$) again increased significantly. The pattern of results was similar for SSS-Community with the variance accounted for at each step as follows: Step 2, $R^2 = .636$, $F(8, 115) = 25.074$, $p < .001$; and Step 3, $R^2 = .684$, $F(9, 114) = 27.387$, $p < .001$. See Table 2 for detailed results. Interaction results are visualized in Figure 1. The simple slopes for both low SSS (SSS-U.S.: $\text{Beta} = .5819$, $p < .001$; SSS-Community: $\text{Beta} = .5545$, $p < .001$) and high SSS (SSS-U.S.: $\text{Beta} = .3395$, $p < .001$; SSS-Community: $\text{Beta} = .3368$, $p < .001$) were significant. However, relative to participants with high SSS, the association between AS and anxiety symptoms were enhanced among participants with low SSS. The Johnson-Neyman technique revealed no significant transition points for either social status ladder.

With regard to depressive symptomatology, covariates entered at Step 1 accounted for a significant amount of variance ($R^2 = .657$, $F(6, 117) = 37.356$, $p < .001$) and NA was the only significant predictor. At Step 2, both AS and SSS-US were significant predictors and the variance accounted for ($R^2 = .715$, $F(8, 115) = 36.046$, $p < .001$) increased significantly. However, at Step 3, neither the interaction term between AS and SSS-US nor the variance accounted for by the addition of the interaction term was significant (see Table 2). The pattern of results was similar for SSS-Community, except that the main effect of SSS-Community in Step 2 did not meet the threshold of statistical significance ($p = .076$). Specifically, the variance accounted for at each step in models including SSS-Community were as follows: Step 2, $R^2 = .702$, $F(8, 115) = 33.880$, $p < .001$; and Step 3, $R^2 = .702$, $F(9, 114) = 29.857$, $p < .001$. Interaction results are visualized in Figure 1. The simple slopes for both low SSS (SSS-U.S.: $\text{Beta} = .2123$, $p < .001$; SSS-Community: $\text{Beta} = .2197$, $p < .001$) and high SSS (SSS-U.S.: $\text{Beta} = .2171$, $p < .001$; SSS-Community: $\text{Beta} = .2141$, $p < .001$) were significant. The Johnson-Neyman technique revealed that the significant transition point on the SSS-US ladder (not mean centered) was 1.12 (99.2% of observations were above this

value and the effect of the focal predictor was not significant). There were no significant transition points for the SSS-Community ladder (not mean centered).

DISCUSSION

The present study was responsive to the cited need for further inquiry into the interplay between anxiety sensitivity and social status on the expression of anxious and depressive symptomatology,³² and the first, to our knowledge, to examine these associations among a community sample of Black adults. Results for anxiety symptomatology were consistent with predictions, whereby co-occurring higher levels of anxiety sensitivity and lower levels of social status were associated with greater anxiety symptomatology. The significance of the interaction between anxiety sensitivity and social status is notable given that the covariates in the model and main effects of anxiety sensitivity and social status alone accounted for 64%–65% of the variance for anxiety symptoms, depending on SSS ladder. Indeed, the addition of the interaction variable into the models explained a modest but incremental 5% over the previous step. Together, results suggest that Black adults with higher anxiety sensitivity and lower social status may be at an enhanced risk for anxiety symptomatology expression. Although beyond the scope of the present study, it is possible that individuals with such a phenotype may benefit from transdiagnostic interventions to address anxiety sensitivity, which have been shown to reduce psychological symptomatology in clinical samples⁴ and which may prevent the development of clinical disorders. In addition, results speak to the consideration of anxiety sensitivity as a relevant factor in explanatory models postulating the ways in which social determinants affect mental, and ultimately physical, health and contribute to health disparities experienced by Black adults. Of note, post-hoc analyses examining interactions between social status and each of the subscales of the ASI (cognitive, physical, and social) yielded similarly significant results (available from the corresponding author upon request).

Contrary to hypotheses, social status did not interact with anxiety sensitivity on depressive symptoms. These results differed from those recently reported with a sample of Latino patients in primary care settings, where high anxiety sensitivity and low social status were associated with greater levels of depressive symptoms.³² Differing results between studies may reflect differences in the measures used to assess depressive symptoms (the CESD versus the Inventory of Depressive and Anxiety Symptoms⁴⁷), the severity of mental health symptomatology between samples (28.5% of those in the previous study had current/recent depressive disorders³² versus 9.7% with probable depression⁴² in the current sample), or other distinguishing factors (e.g., treatment-seeking versus community sample). Indeed, the correlation between the CESD and negative affectivity (a covariate) was quite high in this sample ($r=.79$). However, post-hoc analyses excluding negative affectivity as a covariate still did not yield significant anxiety sensitivity by social status interactions in their association with depressive symptoms in our sample. Although replication is indicated, the present results suggest that lower social status lends no additional interactive risk when combined with higher anxiety sensitivity on depressive symptoms among Black adults. Future work in this area, however, should use more contemporary measures of mood states that tap into the common and specific features of mood/anxiety phenotypes, such as the Inventory of Depression and Anxiety Symptoms.

Both the socioeconomic and the community versions of the social status ladder were used in this study. Findings, however, were largely consistent using both ladders as indicated by the overall pattern of results as well as the variance accounted for by the covariates and main effects (Steps 1 and 2), although the SSS-U.S. ladder performed slightly better overall (1%–3% more variance accounted for in the models). Overall, although the SSS-U.S. and SSS-Community ladders were only moderately (though significantly) correlated in the present sample, their respective use did not yield rich data about the dimensionality of social standing and its effect on mental health symptomatology, either alone or in an interaction with anxiety sensitivity, among this sample. Although the use of both SSS ladders is recommended for health-related studies involving groups of potentially lower socioeconomic status,¹⁹ the current sample was largely educated (almost 50% had a bachelor's degree or more education) and the majority (~60%) of participants were employed. Therefore, the lesser-used SSS-Community ladder might be more relevant among samples with greater socioeconomic diversity: a prospect that can be investigated in future work.

In addition to the interaction effects that were the main purpose of the current study, there were also significant main effects for both anxiety sensitivity and social status in their association with anxiety symptoms and depressive symptoms, even after controlling for negative affectivity and traditional indicators of socioeconomic status (e.g., education and employment status). Specifically, anxiety sensitivity was positively, and social status was negatively, associated with both criterion variables. Although social status has been associated with greater psychological symptomatology in many previous studies,^{18,20–25} the current study is novel for the extension of associations between anxiety sensitivity and anxiety and depressive symptoms to a diversely-aged, Black community sample of adults. Overall, the present results suggest a unique and potentially explanatory role for anxiety sensitivity in psychological symptomatology expression, including depressive symptoms, among Black adults. Anxiety sensitivity represents a transdiagnostic risk factor for the development and maintenance of anxiety and depression, and thus one that can be intervened upon to reduce symptomatology and perhaps prevent the development of clinically severe disorders.⁴ Future studies might examine the utility of (transdisagnostic) anxiety sensitivity interventions for ameliorating symptomatology or preventing mental health disorders among Black adults with elevated anxiety sensitivity.

Study limitations include the use of a community sample of individuals who were willing to participate in overall study procedures, which included the collection of saliva samples. In addition, the sample predominately comprised women. Therefore, results may not be representative of the broader Black population. In addition, participant recruitment originated from and data collection occurred within a church setting, and the proportion of non-church attendee participation in the study was unknown. Although the majority of Black adults (particularly women) attend church regularly,⁴⁸ results may not be generalizable to non-church attending or affiliated persons. Also worthy of consideration is the possibility that the social support provided/experienced in the church setting and the religiosity of a church-based sample might have protective effects against the development and experience of mental health symptomatology and associated vulnerabilities. However, it is notable that significant findings emerged in this sample despite the potential for mitigated mental health

symptomatology as well as limited variability in educational achievement and employment status leading to potentially high SSS ladder rankings. As such, it is possible that stronger associations might be expected among samples more reflective of population norms. Likewise, anxiety sensitivity and social status might possibly interact on depressive symptoms to a significant degree among samples that do not benefit from church support and relatively high SSS. Taken together, limitations of the sample suggest the importance of replicating these results among other samples of Black adults. In addition, the current study was cross-sectional, and focused on symptomatology as opposed to clinical disorders. Future studies could explore the impact of the interaction of anxiety sensitivity and social status on both the development and maintenance of psychological disorders to better understand the relevance that interventions to address anxiety sensitivity might have on mental health problems among Black adults. A focus on the specific subcomponents of anxiety sensitivity was not pursued in this study due to power issues, but would be of interest in future research especially in as much as previous work has highlighted the potential relevance of the physical concerns subscale among Black adults.¹³ Finally, future work might also further explore mechanisms contributing to the nuanced relationships between the respective SSS scales and depressive symptomatology, given the lack of a significant association with SSS-Community ladder in this sample.

CONCLUSIONS

In summary, results of the current study supported an interaction between anxiety sensitivity and social status in relation to anxiety symptomatology in a community sample of Black adults. Results extend recent findings supporting an interplay between this cognitive vulnerability factor and social status, a salient social determinant of health, from Latinos recruited from a primary care to diversely-aged Black adults recruited from a church setting, and suggest a unique and potentially explanatory role for anxiety sensitivity and social status in anxiety symptomatology. The consistency of results in this regard between the socioeconomically- and community-based SSS ladders highlights the potential role of this social determinant in psychological vulnerability-risk paradigms. Overall, results suggest that Black adults who have high anxiety sensitivity and low social status may be at heightened risk for anxiety symptomatology and may benefit from interventions to reduce anxiety sensitivity. This formative line of research would benefit from future prospective studies to examine the potential utility of targeting high anxiety sensitivity-low social status individuals for transdiagnostic interventions to prevent disorders and ameliorate sub-clinical mental health symptomatology.

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Figure 1.

Simple slopes of anxiety and depressive symptoms as a function of the interaction between anxiety sensitivity and social status (Mean = +1 SD and Mean = -1 SD). Low SSS-U.S. = Subjective Social Status-U.S. at Mean - 1 SD; High SSS-U.S. = Subjective Social Status-U.S. at Mean + 1 SD; Low SSS-Community = Subjective Social Status-Community at Mean - 1 SD; High SSS-U.S. = Subjective Social Status-Community at Mean + 1 SD. *Note.* Actual ladder values were used for visualization purposes to enhance clinical relevance, mean-centered variables were used for statistical analyses.

Table 1

Participant characteristics and zero-order correlations between study variables (N=124).

	1	2	3	4	5	6	7	8	9	10	11	Mean (or n)	SD (or %)
1. Sex (% female)	1	-0.12	-0.26**	0.06	0.14	0.18*	0.19*	0.03	0.02	-0.08	-0.08	(98)	(79.0)
2. Age		1	0.15	-0.003	0.139	-0.1	-0.18	-0.28**	-0.33**	0.31**	0.20*	49.02	11.47
3. Partner Status (% partnered)			1	0.06	-0.14	-0.18*	-0.18*	-0.29**	-0.21*	0.11	0.06	(50)	(40.3)
4. Education (% < bachelors)				1	-0.17	-0.08	-0.05	-0.15	-0.07	0.18	0.29**	(64)	(51.6)
5. Employment (% employed full time)					1	-0.02	0.14	0.06	-0.05	-0.04	-0.05	(74)	(59.7)
6. Anxiety Sensitivity						1	0.96**	0.55**	0.48**	-0.05	-0.11	9.75	11.42
7. Anxiety Symptoms							1	0.67**	0.59**	-0.28**	-0.33**	6.05	9.66
8. Depressive Symptoms								1	0.79**	-0.34**	-0.39**	9.79	10.35
9. Negative Affectivity									1	-0.33**	-0.31**	16.87	6.82
10. SSS-Community										1	0.62**	7.00	1.67
11. SSS-U.S.											1	6.36	1.67

*Note:**
p .05;**
p .01.

SSS=Subjective Social Status. Anxiety Sensitivity was assessed with the Anxiety Sensitivity Index III. Anxiety symptoms were assessed with the Beck Anxiety Inventory. Depressive Symptoms were assessed with the Center for Epidemiologic Studies Depression scale. Negative affectivity was assessed with the negative affect subscale of the Positive and Negative Affect Schedule.

Table 2

Hierarchical regression models for interactive effects of anxiety sensitivity and social status on anxiety and depressive symptoms (N=124).

Anxiety Symptoms				Depressive Symptoms			
		Beta	p	R ²	Beta	p	R ²
<i>Step 1</i>	Sex	0.172	0.022	0.417*	Sex	-0.019	0.744
	Age	0.024	0.752		Age	-0.031	0.592
	Partner Status	0.013	0.866		Partner Status	-0.114	0.051
	Education	0.012	0.869		Education	-0.077	0.165
	Employment	0.151	0.043		Employment	0.077	0.177
	Negative Affectivity	0.615	<.001		Negative Affectivity	0.757	<.001
SSS-U.S.							
<i>Step 2</i>	SSS-U.S.	-0.190	<.001	0.227*	SSS-U.S.	-0.162	<.001
	ASI	0.536	<.001		ASI	0.237	<.001
<i>Step 3</i>	ASI*SSS-U.S.	-0.257	<.001	0.054*	ASI*SSS-U.S.	0.005	0.932
SSS-Community (SSS-C)							
<i>Step 2</i>	SSS-C	-0.159	0.013	0.219*	SSS-C	-0.102	0.076
	ASI	0.545	<.001		ASI	0.240	<.001
<i>Step 3</i>	ASI*SSS-C	-0.238	<.001	0.048*	ASI*SSS-C	-0.006	0.918

Note:

* p < .001.

SSS = Subjective Social Status. ASI = Anxiety Sensitivity. Anxiety Sensitivity was assessed with the Anxiety Sensitivity Index III. Anxiety was assessed with the Beck Anxiety Inventory. Depressive Symptoms were assessed with the Center for Epidemiologic Studies Depression scale. Negative Affectivity was assessed with the negative affect subscale of the Positive and Negative Affect Schedule. Binary covariates were coded as follows: male = 1 (sex); not partnered = 0, partnered = 1 (partner status); < Bachelor's degree = 0, Bachelor's degree = 1 (education); and employed full time = 0, not employed full time = 1 (employment).