Why do I feel what I feel? Examining individual differences in meta-mood knowledge as a moderator of the relationship between anxiety and depression in adolescents

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Abstract

The aim of this study is to analyze whether dimensions of meta-mood knowledge (i.e., attention to emotion and emotional clarity) moderate the relationship between anxiety and depression. A sample of 258 adolescents aged 12 to 18 years (M = 14.6, SD = 1.7, 54.5% girls) was examined to investigate the moderating role of attention to emotion and emotional clarity on the relationship between anxiety and depression. A regression-based moderation analysis controlling for age, gender, and socioeconomic status was conducted. The results showed that attention to emotion and emotional clarity moderated the relationship between anxiety and depression. Moreover, the positive relationship between anxiety and depression was statistically significant in all cases (i.e., high attention and low clarity: b = 0.362, p < .001, low attention and low clarity: b = 0.184, p < .001; high attention and high clarity: b = 0.183, p = .001), with one exception (i.e., low attention and high clarity: b = 0.004, p = .929). This study highlights the importance of understanding individual differences in attention to emotion and emotional clarity in order to benefit more from treatments and prevention programs that incorporate emotional self-awareness as an active component.

Keywords: Anxiety, depression, meta-mood knowledge, emotional awareness, attention to emotion, emotional clarity

1. Introduction

Anxiety and depression are the most common internalizing psychopathologies in the general and clinical population, both in their clinical and subclinical forms. The global prevalence of anxiety and depression in children and adolescents is estimated at 6.5% for anxiety and 2.6% for depression (Polanczyk et al., 2015). A recent meta-analysis estimated the pooled prevalence of anxiety to be 19.1% (19 studies) and the pooled prevalence of depression to be 14.3% (36 studies) in young people with a life-limiting condition (mean age: 15.4 years) (Barker et al., 2019). Furthermore, co-occurrence of anxious and depressive symptoms is one of the most common examples of comorbidity (Costello et al., 2003; Essau, 2003). In a sample of adolescents, the comorbidity of anxiety and depression was estimated to be 72% and 62% in outpatient and clinical settings, respectively, with the presence of anxiety preceding depression (Essau, 2008).

A study of emotion regulation showed that only the subclinical anxious-depressed group had unique problems with emotion regulation (i.e., nonacceptance of emotional reactions and difficulties with impulse control) (Shukla & Pandey, 2021). Although adolescence is a critical time for mental health and specific mental disorders peak at age 14.5 (Solmi et al., 2021), comorbid anxiety and depressive symptoms in children and adolescents receive less attention than in adults and are understudied in the nonclinical population (Melton et al., 2016). In addition, emotion regulation skills are still developing in adolescence, which may increase vulnerability to emotional difficulties related to anxiety and depression in adolescents (Young et al., 2019).

Importantly, anxiety associated with depression is often more difficult to treat and requires better, more specialized treatments (Frank et al., 2020). Early interventions at this developmental stage, when symptoms are at subclinical levels and/or before clinical disorders emerge, can help improve adolescent mental health by providing opportunities to understand risk factors associated with anxiety and depression (Garber & Weersing, 2010). Thus, understanding moderating factors such as knowledge of meta-moods

is critical in this context. And any effort to improve emotion regulation strategies in adolescents could have the potential to reduce the occurrence of anxiety and depressive symptoms even at subclinical levels.

1.1. Meta-Mood Knowledge

Meta-mood knowledge or emotional self-awareness is defined as the way individuals perceive and understand their affective world (Salovey et al., 1995). Its two core dimensions: Attention to Emotion (i.e., the willingness to pay attention to emotions) and Emotional Clarity (i.e., the ability to name and define emotional states) are more thoroughly explored in the literature. This is primarily because both play an active role in emotion processing, emotion regulation, and the development of adaptive coping strategies (Boden & Thompson, 2017; Eckland & Berenbaum, 2021). From this perspective, awareness of one's emotions contributes to "salutogenesis," which is associated with better social interactions and mental health (Luyten et al., 2020). And most importantly, emotional self-awareness has been studied in this context as a general protective factor for mental health (e.g., Ballespí et al., 2018, 2021).

1.2. Attention to Emotion and Emotional Clarity Dimensions

Previous studies have shown that attention to emotion and emotional clarity contribute to mental health processes in different ways. For example, emotional clarity has been explicitly linked to happiness (Extremera et al., 2011), well-being (Gohm & Clore, 2002; Lischetzke & Eid, 2017), less stress (De la Barrera et al., 2021), and greater life satisfaction (Extremera et al., 2009). In addition, low emotional clarity has been found to be associated with depressive symptoms (Blöte & Westenberg, 2019) but not with anxious arousal-type symptoms (Vine & Aldao, 2014).

The attention to emotion dimension, on the other hand, has been associated with the intensity of (negative) emotional experiences (Thompson et al., 2009), the duration of stress (Vives et al., 2021), and an increased risk of internalizing disorders (Ciarrochi et al., 2002). This dimension also differs in its function in anxious individuals due to the arousal factor and physiological cues (e.g., rapid breathing,

increased heart rate) (Lea et al., 2019). In addition, lower levels of attention to emotion have been predicted to be associated with recovery from major depressive disorder (Thompson et al., 2013).

To our knowledge, however, no previous study has examined the role of attention to emotion and emotional clarity, both individually and in combination, in the relationship between anxiety and depression. Exploring individual differences in emotional self-awareness, even at subclinical levels of anxiety and depression, could help prevent progression to more complex forms of internalizing psychopathology.

1.3. Aims and Hypotheses

The aim of the present study was to investigate the extent to which these two dimensions moderate the relationship between anxiety and depression. We hypothesized that emotional clarity would buffer this relationship, but attention to emotion would not. According to the relevant literature (e.g., Boden & Thompson, 2017), we also hypothesized that the combination of high attention and low clarity would exacerbate this relationship between anxiety and depression, raising the question of how other combinations would affect this relationship, including balanced combinations (i.e., low attention and low clarity; high attention and high clarity).

2. Method

2.1. Participants

The sample of the current study consisted of 264 adolescents (144 girls, 54.5%) aged 12 to 18 years (M = 14.7, SD = 1.7) from Catalonia (Spain). Of all participants, 42.4% were 12-13 years old, 33.0% were 14-15 years old, and 24.6% were 16-18 years old. Socioeconomic status (SES) was measured using the Hollingshead Four Factor Index. More than half of the parents reported their SES as middle socioeconomic level.

The inclusion criterion was healthy adolescents aged 12 to 18 years without a diagnosed medical condition. The exclusion criterion was students who did not complete the questionnaires, including demographic characteristics. Six participants were excluded before performing the statistical analysis because required information was missing and one or more scales were not completed.

2.2. Measures

Table 1 provides further details on each measurement used in the current study, including values for mean, standard deviation, skewness, and kurtosis.

2.2.1. Attention to Emotion and Emotional Clarity

Trait Meta-Mood Scale (TMMS-24; Salovey et al., 1995; Spanish adaptation: Fernandez-Berrocal et al., 2004). The TMMS-24 consists of three dimensions: Attention to Emotion, Emotional Clarity, and Mood-Repair. The Attention to Emotions subscale was used to assess the extent to which individuals are willing to pay attention to their emotional states. It consists of eight items such as "I pay a lot of attention to how I feel." And the subscale Emotional Clarity was used to assess the clarity of one's emotional states. It consists of eight items such as "I am usually very clear about my feelings." In the present study, only these two dimensions were used. In the questionnaire, participants indicated how much they agreed with each statement on a 5-point scale ranging from 1 (strongly disagree) to 5 (strongly agree). The Spanish version of the scale has shown good validity and reliability in the Spanish population (e.g., Fernandez-Berrocal et al., 2004). The Cronbach's alphas for the attention to emotion and emotional clarity subscales in this study were .90 and .92, respectively.

2.2.2. Anxiety

Multidimensional Anxiety Scale for Children (MASC-39; March et al., 1999; Spanish adaptation: García-Villamisar et al., 2002). The MASC total score was used, which refers to the severity of anxiety

and includes four main subscales: physical symptoms, harm/avoidance, social anxiety, and separation anxiety. The questionnaire asks participants to rate the extent to which each item applies to them on a 4-point scale ranging from 0 (never applies) to 3 (often applies). The Spanish version of the scale has shown good validity and reliability in the Spanish population (e.g., García-Villamisar et al., 2002). The Cronbach's alpha for the scale in the present study was .88. In a nonclinical sample (e.g., Muris et al., 2002), the mean score for total anxiety was 38 (*SD* = 18.8), and Ivarsson (2006) found a similar result. In a clinical sample (e.g., Wei et al., 2014), the mean total score was 56.4 (*SD* = 19.1).

2.2.3. Depression

Beck's Depression Inventory - II (BDI-II-21; Beck et al., 1996; Spanish adaptation: Sanz et al., 2003). The BDI-II was used to measure the severity of depression, such as "feelings of sadness," "suicidal thoughts," and "loss of energy." In the questionnaire, participants rated their response for each item-specific text on a 4-point scale ranging from 0 (symptom absent) to 3 (symptom strongly present). The Spanish version of the scale has shown good validity and reliability in the Spanish population (e.g., Sanz et al., 2003). The Cronbach's alpha for the scale in the present study was .90. In a nonclinical sample (e.g., Osman et al., 2008), the mean total depression score was 12.5 (*SD* = 10.5). In an inpatient psychiatric sample (e.g., Osman et al., 2004), the mean total depression score was 17.7 (*SD* = 12.6).

2.3. Procedure

The present study was approved by the institutional ethics committee of the home institution (***hidden code for peer review***), and the procedures used in this study conform to the principles of the Declaration of Helsinki. Participants were recruited from five different secondary schools in Catalonia (Spain). After consultation with the school principals, the questionnaires were distributed in envelopes during school hours. The order of delivery of the envelopes and timely return was as follows: Researcher - Secondary School Secretariat - Teacher - Children - Families/Home, with return in reverse order. The steps and necessary guidelines for completing the questionnaires were explained both in writing and

verbally in each classroom. All participants were assigned a code to ensure confidentiality, and in the event of missing data or a due date, participants were identified by this predetermined unique code.

2.4. Statistical Analysis

The aim of this study was to examine whether attention to emotion and emotional clarity can moderate the relationship between anxiety and depression, controlling for the effects of socioeconomic status (SES), gender, and age. Before data analysis, we tested the assumptions of linearity, homoscedasticity, absence of multicollinearity, independence, and normality of error. After confirming that the assumptions were met, we proceeded with the regression-based moderation analysis. The regression-based moderation analysis was conducted using PROCESS version 3.5, model 2 (Hayes, 2018). In addition, the moderating effects of attention to emotion and emotional clarity were assessed using the 16th (low) and 84th (high) percentiles to cover the important data points of the distribution, while ensuring that the chosen values were within the range of measurement (Hayes & Rockwood, 2017).

All analyses were conducted using IBM Statistics Package for Social Science (SPSS), version 27, with statistical significance considered at the .05 alpha level.

In addition, a sensitivity power analysis was conducted using G*Power 3.1 (Faul et al., 2009) for the regression analysis with 258 participants and six predictors (one exposure, two moderators, three covariates). The minimum required sample size was calculated: 251 participants for 90% power (alpha = .05) to obtain effect sizes of 0.15 (Cohen's f^2), which is between small ($f^2 \geq 0.02$) and medium ($f^2 \geq 0.15$) effect sizes (Cohen, 1988).

3. Results

Descriptive statistics are shown in **Table 1**. Mean and standard deviation of anxiety (M = 42.3, SD = 14.9, range 11- 84) and depression (M = 9, SD = 8.2, range 0 - 49) were lower than clinical scores.

Pearson correlation coefficient results are also shown in **Table 1.** The correlation results between the variables were in the expected direction, as anxiety and attention to emotion were positively correlated with depression.

The results of the overall model including the effects of anxiety, attention to emotion, and emotional clarity on depression are shown in **Table 2a**. Anxiety score was positively associated with depression (b = 0.178, p < .001). As hypothesized, emotional clarity showed a buffering effect on the relationship between anxiety and depression (b = -0.011, p = .001), but attention to emotion did not (b = 0.012, p = .002). We went a step further and formally probe the moderating effects using the 16th (low) and 84th (high) percentiles of moderator variables, as shown in **Table 2b** and **Figure 1**. Of the four combinations, only low attention and high clarity appeared to have the potential to promote the positive experience of meta-mood. The combination of high attention to emotion and low emotional clarity produced the largest change in the relationship between anxiety and depression (b = 0.362, p < .001). This was followed by low attention and low clarity (b = 0.184, p < .001) and high attention and high clarity (b = 0.183, p = .001). Interestingly, there was no statistically significant association between anxiety and depression for low attention and high clarity (b = 0.004, p = .929).

4. Discussion

The present study examined how attention to emotion and emotional clarity moderated the association between anxiety and depression in adolescents from the general population. Importantly, our results showed that individual differences in attention to emotion and emotional clarity can provide information about negative emotional imbalance (i.e., high attention and low clarity) and positive emotional imbalance (i.e., low attention and high clarity). This negative emotional imbalance has already been interpreted in the literature in relation to emotion regulation problems and psychopathological conditions (Boden & Thompson, 2017). Specifically, our results suggest that the combination of high

attention and low clarity is associated with increased risk for anxiety and depression. Indeed, any combination with high attention was not conducive to emotion processing, which is consistent to some extent with previous studies addressing the detrimental effects of the attention dimension (e.g., Ciarrochi et al., 2002; Thompson et al., 2009, 2013; Vives et al., 2021) and despite the positive value of emotional clarity (e.g., Eckland & Berenbaum, 2021; Gohm & Clore, 2002).

From this perspective, low attention (to emotions) is more beneficial and could indicate less affect-driven, but more conscious and reflective emotion processing (Ballespí et al., 2019; Luyten et al., 2020). This could partially explain why high emotional clarity requires less attention or how and when it is associated with increased or decreased risk for psychopathological disorders. There are also studies that point to the detrimental effect of the attentional dimension, with the fact that it is more likely to occur when anxiety is elevated (e.g., Lea et al., 2019). In addition, low but not high levels of attention to emotion have been found to be associated with better recovery from depression (Thompson et al., 2013). Taken together, we can highlight the importance of positive imbalance (i.e., low attention and high clarity), which seems to be the most favorable emotional state. And the negative imbalance (i.e., high attention and low clarity), which may specifically indicate an increased risk for the co-occurrence of anxiety and depression.

4.1. Applied Implications

The current findings may provide valuable insights to teachers, counselors, and public health professionals. Selective screening and psychoeducational interventions (or school-based interventions) can be helpful and supportive for adolescents and parents in alleviating emotional difficulties, especially when used in practice. This is important because the ability to recognize and understand one's own feelings and emotional states is considered a necessary tool for effective interventions (e.g., Lischetzke & Eid et al., 2017; Salguero et al., 2012). In this sense, our research findings underscore the importance of understanding what level of attention is required to promote psychological resilience through emotional

clarity. Considering that negative emotional imbalance may be the hallmark of the difficulties associated with anxiety and comorbid depression.

4.2. Theoretical Implications

The current study applied a multidimensional approach to attention to emotion and emotional clarity that may have conceptual implications. This is because it provides the opportunity to ask when or under what circumstances or for what types of individuals this effect does or does not exist and to what extent. Low attention and high clarity, for example, may indicate better experience of meta-mood, which has been associated with psychological resilience and positive mental health in adolescents (e.g., Ballespí et al., 2018). In this sense, our findings may contribute to the literature on uneven profiles of attention to emotion and emotional clarity, which have been associated with "positive emotional imbalances" and "negative emotional imbalances" or the "dark side" of emotional intelligence, depending on context (Boden & Thompson, 2017; Davis & Nichols, 2016). That is, certain patterns have the potential to contribute to problems related to emotion regulation and mental health in general.

4.3. Limitations and Future Directions

Nevertheless, the current study also has some limitations. First, the cross-sectional nature of the observational design limits the interpretability of the results in terms of cause-effect relationships. Second, the sample of the current study was recruited from selected schools that are located within a short distance of each other and therefore have relatively similar demographic characteristics. Third, our results are limited to the nonclinical and young population aged 12 to 18 years. Future research could extend the results of the current study with experimental or longitudinal studies to examine, for example, whether there are causal effects and whether individual differences in metaknowledge mediate this risk for the co-occurrence of anxiety and depression. In addition, including adolescents from different ethnic/cultural backgrounds in future studies could improve the generalizability of findings to a broader

setting. Finally, it would be interesting to develop future research that focuses on a clinical sample in the context of assessment for diagnosis and intervention.

5. Conclusion

With the current study, we have shown that individual differences in meta-mood knowledge may indeed indicate, even at a subclinical level, the risk factors for elevated symptom scores. Therefore, the use of psychometrically sound and cost-effective screening tools may help identify potential risk factors for subclinical anxiety and co-occurring anxiety and depression. For example, adolescents who score low on the attention dimension but high on the clarity dimension might be considered less prone to "mixed" internalizing symptoms. In this sense, emotional self-knowledge (knowing why I feel what I feel) seems to be an essential tool, a pathway to "salutogenesis" and psychological resilience. Finally, caution is needed in promoting a better meta-mood experience. It seems necessary to understand when and how this may prove beneficial or detrimental by examining individual differences in attention to emotion and emotional clarity.

Table 1

Descriptive statistics and Pearson correlation coefficients for the study variables

	M (*SD*)	Skewness	Kurtosis	1	2	3	4
1.Anxiety	42.3 (14.9)	0.18	-0.40	1			
2.Depression	9 (8.2)	1.62	3.55	.439**	1		
3.Attention	23 (7.0)	0.13	-0.66	.329**	.283**	1	
4.Clarity	24.8 (7.3)	0.15	-0.53	-.221**	-.359**	.194*	1

Note. *M* = Mean. *SD* = Standard deviation.

*Correlation is significant at the .05 level (2-tailed).

**Correlation is significant at the .01 level (2-tailed).

Table 2a

Conditional main and moderating effects on depression

	b	*p*	95 % CI
Anxiety	0.178	$p < .001$	[0.118, 0.237]
Anxiety x Attention	0.012	$p = .002$	[0.005, 0.019]
Anxiety x Clarity	-0.011	$p = .001$	[-0.018, -0.005]

Note. *b* = regression coefficient; 95 % CI = 95 % confidence interval.

The overall model was significant (F (8, 249) = 22.32, $p < .001$, $R^2 = .418$).

Table 2b

Moderating effects of attention to emotion and emotional clarity

	b	*p*	95 % CI
High AE - low EC	0.362	$p < .001$	[0.263, 0.462]
Low AE - low EC	0.184	$p < .001$	[0.091, 0.276]
High AE - high EC	0.183	$p = .001$	[0.077, 0.290]
Low AE - high EC	0.004	$p = .929$	[-0.088, 0.097]

Note. High = Adolescents who scored in or above the 84th percentile.

Low = Adolescents who scored in or below the 16th percentile.

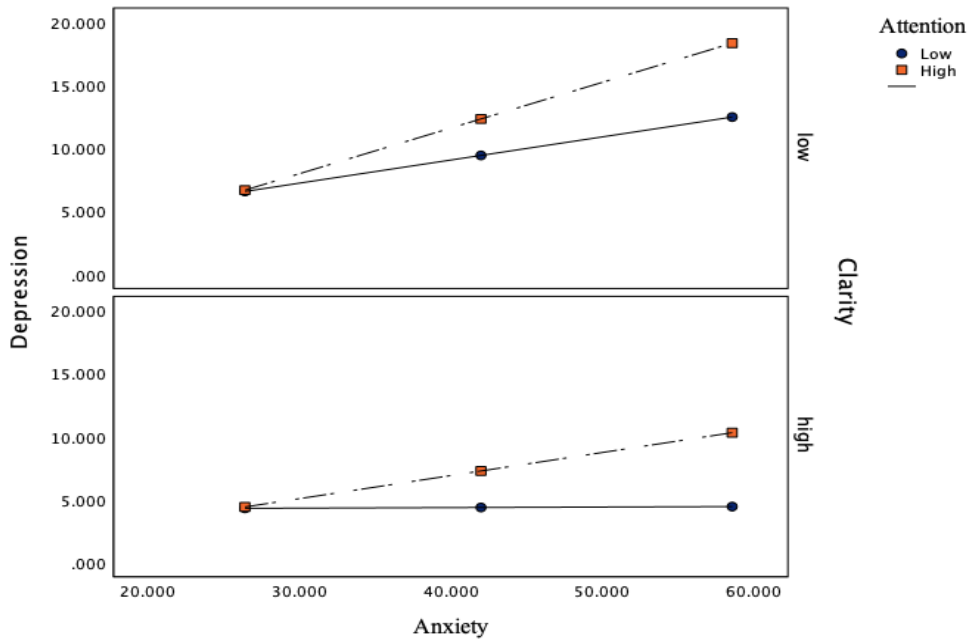

Fig.1. Moderating effects of attention to emotion and emotional clarity on the relationship between anxiety and depression, at the 16th and 84th percentiles of low and high scores.

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