Anxiety and Depression: The Moderating Effects of Attention to Emotion and Emotional Clarity

Abstract

Anxiety and depression are the most common mental health problems. They often occur together and significantly affect well-being and daily functioning. However, it is unclear to what extent the two dimensions of meta-mood knowledge play a role in their comorbidity. Therefore, the aim of the current study was to examine the role of attention to emotion and emotional clarity in the relationship between anxiety and depression. A sample of 256 adults aged 32 to 66 years ($M = 46.21$, $SD = 5.53$; 82.03% women) completed questionnaires on anxiety, depression, and meta-mood knowledge. Results showed that emotional clarity buffered the relationship between anxiety and depression. In addition, all combinations of attention to emotion and emotional clarity showed a significant and positive relationship with anxiety and depression symptom severity, with one exception. Interestingly, there was no statistically significant relationship between anxiety and depression when attention to emotion was low and emotional clarity was high. This last condition was interpreted as beneficial rather than detrimental, which in turn could help promote psychological resilience to better cope with emotional difficulties. Given these findings, this study highlights the role of attention to emotion and emotional clarity in assessing anxiety and risk of comorbid depression.

Keywords: Anxiety, depression, comorbidity, attention to emotion, emotional clarity, emotionally overwhelmed.

Introduction

Anxiety and depression are the most common mental health problems worldwide and increase with age (WHO, 2017, 2021). In the general population, anxiety disorders are reported as the most common mental illness (12-month prevalence approximately 11%), while mood disorders are the next most common disorder (12-month prevalence approximately 6%) (Kessler et al., 2009). In a cross-national epidemiological study of anxiety disorders and major depression, the 12-month prevalence of major depression combined with at least one 12-month anxiety disorder was estimated to be 41.6% (Kessler et al., 2015).

Previous studies have already examined what lies behind the co-occurrence of anxiety and depression, including overlapping features (e.g., negative affect and stressful life events) and distinguishing features (e.g., the nature of the events, whether past- or future-oriented) (Eysenck et al., 2006; Eysenck & Fajkowska, 2018). Along these lines, anxiety is later discussed in the context of "uncertainty" and associated with the possibility that it may be triggered in part by heightened threat awareness and hypervigilance (Grupe & Nitschke, 2013).

In addition, one study examined the role of cognitive (e.g., daily rumination, perceived rejection) and interpersonal functioning (e.g., rejection, criticism) as moderators of the relationship between anxiety and depressive symptoms in individuals diagnosed with generalized anxiety disorder (Starr & Davila, 2012b). Another study examined the possible differential relationships (i.e., additive, curvilinear, and interactive) of anxiety and depression in a sample of healthy individuals as indicators of psychosocial functioning (Cowden et al., 2021). The important fact that anxiety and depression co-occur, with or without meeting criteria for a diagnosis, is significant as part of the clinical presentation (Hirschfeld, 2001).

Previous studies on the comorbidity of anxiety and depression have shown that anxiety disorders are more likely to precede a depressive disorder (Lamers et al., 2011; Starr & Davila, 2012a). However, little is known about a person's emotional metaknowledge and the role it plays in this relationship between anxiety and depression. This leads us to ask to what extent dimensions of emotional metaknowledge (or emotional self-awareness) contribute to this co-occurrence. In this sense, the dimensions of attention to emotion and emotional clarity are commonly used in the literature and in the assessment of emotional self-awareness.

This ability to perceive and understand one's emotions is an essential component of emotional intelligence (Goleman, 1995; Salovey et al., 1995), intrapersonal intelligence (Gardner, 2006), or mentalizing (Bateman & Fonagy, 2013). Although these terms are used interchangeably depending on the context (for reviews, see Fernández-Berrocal & Extremera, 2008; Luyten et al., 2020). Attention to emotion and emotional clarity are the underlying dimensions of a person's ability to perceive and understand emotional or mental states.

Although both dimensions are necessary emotional components for better coping skills and well-being (e.g., Eckland & Berenbaum, 2021). It is important to note previous studies that emphasize the positive value of emotional clarity (i.e., understanding, identifying, and clarifying one's emotions) over mere attention to emotions. For example, in a meta-analysis (Boden & Thompson, 2017), the combination of high attention and low clarity was interpreted as being associated with difficulties in emotion regulation, suggesting that the combination of high attention without high clarity may trigger pathological symptoms.

Later, a study examined the relationship between these two emotion dimensions and somatic complaints (Ballespí et al., 2019). It was found that the combination of high attention and low clarity was associated with increased somatic complaints. The authors interpreted this

result as the overwhelming nature of the dimension of attention to emotion when not followed by emotional clarity. In addition, another study suggested that high levels of attention to emotion, when not followed by high clarity, may contribute particularly to the duration of stress in daily life (Vives et al., 2021).

It is also important to note that emotional clarity was negatively associated with anxiety and depression and attention to emotion was positively associated with anxiety and depression in most studies (see, e.g., Fernández-Berrocal & Extremera, 2008, for a review). Moreover, no statistically significant relationship was found between emotional clarity (trait type) and affect intensity (Boden et al., 2013). In contrast, attention to emotion was found to be more consistently associated with negative and positive affect intensity (Thompson et al., 2011). Similarly, high levels of attention to emotion were found in individuals who had not recovered from major depressive disorder (Thompson et al., 2013).

The current study

Given the high prevalence rate for comorbid anxiety and depression, it seems important to examine individual differences in attention to emotion and emotional clarity in this relationship, because it is unclear when and how this might prove beneficial or detrimental. With this in mind, in the current study, we examined the moderating effects of attention to emotion and emotional clarity in the relationship between anxiety and depression. We hypothesized that attention to emotion and emotional clarity would moderate the relationship between anxiety and depression in different ways. It seems more likely that emotional clarity would have a buffering effect on the relationship between anxiety and depression, but attention to emotion would not.

Method

Ethical approval

Ethical approval was granted by the Institutional Review Board (approval number: *concealed code for peer review*), and the study was conducted in accordance with The Code of Ethics of the World Medical Association (Declaration of Helsinki).

Participants

The sample of the current study consisted of 256 participants. The age of the participants ranged from 32 to 66 years ($M = 46.21$, $SD = 5.53$; 82.03% women). Inclusion criteria were that they had not been diagnosed with a mental illness such as psychosis or intellectual disability. All participants were given a brief questionnaire to assess eligibility for participation in the study. Participants who did not complete one or more scales were excluded from the study. One participant was excluded because of missing information on the anxiety measure; therefore, data analysis was conducted with 255 participants. Participants' socioeconomic status (SES) was measured using the Hollingshead Four Factor Index (Socioeconomic Status): 8.98% had high SES, 11.32% had medium-high SES, 18.35% had medium SES, 26.95% had medium-low SES, 12.89% had low SES, and 21.48% had 'not applicable' or unknown SES.

Measures

Trait Meta-Mood Scale (TMMS-24) (Salovey et al.,1995; Spanish version: Fernandez-Berrocal et al., 2004). The TMMS was used to assess emotional self-awareness. For this reason, only the attention to emotion (e.g., "I pay close attention to how I feel") and emotional clarity

(e.g., "I am usually very aware of my feelings") subscales were used. Each subscale consists of eight items. Participants rated their responses on a 5-point Likert scale: 1 = strongly disagree and 5 = strongly agree. In the current study, Cronbach's alpha was .88 for the attention to emotion subscale and .90 for the emotional clarity subscale.

General Health Questionnaire (GHQ-28) (Goldberg & Hillier, 1979; Spanish version: Lobo et al., 1986). The GHQ was used to assess the severity of anxiety and depression symptoms. For this reason, only the anxiety (e.g., "Do you feel that everything is getting on top of you?") and depression (e.g., "Do you feel that life is completely hopeless?") subscales were used. Each subscale consisted of seven items. For each item, participants had four response options: "Not at all," "Not more than usual," "Rather more than usual," and "Much more than usual." Responses were scored using a binary procedure: 'Not at all' and 'Not more than usual' were coded as '0'; 'Rather more than usual' and 'Much more than usual' were coded as '1'. Any score above 4 indicated the presence of distress. In the present study, the Cronbach's alpha for the anxiety subscale was .75 and for the depression subscale was .87.

Procedure

Participants were asked to complete a series of questionnaires about themselves in relation to meta-mood knowledge, anxiety, and depression. An invitation letter was sent to participants who had previously received informed consent and demographic forms as part of a research project on adolescent temperament, coping skills, and mental health. For the current study, an invitation letter was to be sent only to participants who had responded positively when asked if they would like to participate in further studies. Therefore, we re-contacted these participants once this condition was met.

Statistical Analyzes

Prior to the moderation analysis, the data were tested for the assumptions of normality, linearity, homoscedasticity, and multicollinearity. After confirming that the data were consistent with the assumptions, we conducted the regression-based moderation analysis using PROCESS macro version 3.5 (Model 2) (Hayes, 2018). Using Model 2, we analyzed the moderating role of attention to emotion and emotional clarity in the relationship between anxiety and depression. In the model, anxiety was entered as an independent variable, attention to emotion and emotional clarity as moderators, depression as a dependent variable, and gender as a covariate. In addition, as recommended by Hayes (2018), we examined the moderating effects of attention to emotion and emotional clarity using the 16th (low) and 84th (high) percentiles.

Results are presented with linear regression coefficients (b), 95% confidence intervals (95% CI), and p-values (p). Statistical significance of results was considered at the alpha level of .05. All analyses were conducted using IBM Statistics Package for Social Science (SPSS), version 27.

A sensitivity power analysis was conducted using G*Power 3.1 (Faul et al., 2009) for regression analysis with a sample size of 255 and four variables (one predictor, two moderators, one covariate). The sample size needed for an effect size of 0.18 (Cohen's f^2) was 253, for 90% power (alpha = 0.05, one-tailed) (Cohen, 1988).

Results

The results of descriptive statistics showed that the mean score for anxiety was higher than for depression (see **Table 1**). And the results of Pearson correlations showed that emotional clarity was negatively correlated with anxiety and depression. In contrast, attention to emotion was

positively correlated with anxiety. Moreover, there was no statistically significant correlation between attention to emotion and depression (see **Table 1**).

The results of the moderation analysis showed that the overall model was significant (F (6, 248) = 18.22, $p < .001$, $R^2 = .306$), including the conditional main and moderating effects (see **Table 2**). Attention to emotion and emotional clarity moderated the relationship between anxiety and depression in opposite directions. The moderating effect of attention to emotion was positive and statistically significant ($b = 0.018$, $p = .013$). Importantly, the moderating effect of emotional clarity was statistically significant ($b = -0.018$, $p = .010$) and showed a buffering effect on this relationship between anxiety and depression.

The joint effects of attention to emotion and emotional clarity were also significant (F (2, 248) = 5.73, $p = .004$, $\Delta R^2 = .036$). We further probed and plotted these moderating effects using the 16th (low) and 84th (high) percentiles (see **Table 3** and **Figure 1**). Here, the strongest relationship between anxiety and depression was found for the combination of high attention and low clarity ($b = 0.538$, $p < .001$). This was followed by balanced combinations: low attention and low clarity ($b = 0.321$, $p < .001$); high attention and high clarity ($b = 0.319$, $p < .001$). Interestingly, the relationship between anxiety and depression was not statistically significant for the combination of low attention and high clarity ($b = 0.102$, $p = .121$).

Discussion

The current study examined the role of attention to emotion and emotional clarity in the relationship between anxiety and depression. Emotional clarity showed a buffering effect on this relationship, but attention to emotion did not. Importantly, the relationship between anxiety and depression was not statistically significant for the combination of low attention and high clarity.

With the exception of the combination of low attention and high clarity, the other combinations were statistically significant and showed positive associations with the relationship between anxiety and depression.

Of the four combinations, the combination of high attention and low clarity was most strongly associated with increased anxiety and depression. This reinforcing effect of attentional input seems clear, and we further interpret this effect in the context of the overwhelming nature of excessive (negative) attention on emotions when emotional clarity is lacking (e.g., Ballespí et al., 2019). Specifically, there was a positive relationship between the dimension of attention to emotion and the intensity of negative affect (Thompson et al., 2011). Considering that this combination of high attention and low clarity could be characteristic of overwhelmed individuals, who are also more prone to experience high levels of negative affect intensity (Gohm, 2003). Furthermore, this could indicate problems with emotion regulation (Gross & John, 2003). Thus, the current study may partially explain why individuals with high anxiety are at increased risk for comorbid depression.

It is important to point out that attention to emotion, but not emotional clarity, has been shown to be particularly harmful when anxiety has been high. Moreover, the way in which this link between attention to emotion and depression is established seems dubious. To some extent, this interpretation is consistent with previous research that found high levels of attention to emotion, low levels of emotional clarity, and high levels of affect intensity in a group of individuals with depression and worry. In fact, the significance of the results differed when the effect of neuroticism was taken into account for the group of individuals with depression and worry (Berenbaum et al., 2012). This may support the fact that arousal plays an important role in emotion processing (e.g., Kerns & Berenbaum, 2010). In other words, due to the arousal factor,

excessive attention to negative emotions may be activated, which seems to lead to automatic and reflexive negative thinking patterns.

Another point is that the combination of high attention and high clarity has previously been associated with "full emotional insight" or "positive emotional balance" (Ballespí et al., 2019; Boden & Thompson, 2017). From this perspective, individuals who score high on both dimensions (i.e., attention to emotion and emotional clarity) are more likely to achieve better emotion regulation. However, in the current study, the results of the combination of high attention and high clarity were similar to those of the combination of low attention and low clarity. Indeed, the current study may provide evidence that the interplay between dimensions of attention to emotion and emotional clarity differs across the psychopathological spectrum and from the interplay between the presence of symptoms and their potential consequences for psychological functioning or coping style (e.g., Gross & Jazaieri, 2014). Therefore, caution is warranted in attempting to generalize these findings to a broad range of psychopathological conditions.

In the current study, the combination of low attention and high clarity may actually indicate better emotional insight, as anxiety was associated with less depression, especially when considering both the individual and joint effects of these two dimensions of emotion. These findings are consistent with the positive value of emotional clarity for emotion regulation (Gross & John, 2003), healthy coping (Eckland & Berenbaum, 2021), and psychological treatment of anxiety (Gross & Jazaieri, 2014). In addition, emotional clarity has been associated to some degree with lower risk for psychopathological symptoms (Boden & Thompson, 2017; Vine & Aldao, 2014). We therefore interpret that this positive emotional balance is related to emotionally resilient individuals. In other words, it is more likely that emotional clarity has the

potential to act as a protective factor and contributes to better emotion processing. Alternatively, this detrimental effect of the attention dimension on emotions could be an indicator of a lack of clarity about emotions.

Nevertheless, it seems important to point out that the dimension of emotional clarity also reveals, to some extent, its potential downside. In the current study, we found a positive and significant relationship between anxiety and depression for the combination of high attention and high clarity. Indeed, this may suggest that high emotional clarity is not always beneficial, which is consistent with other research on emotional clarity (e.g., Park & Naragon-Gainey, 2019). Inevitably, then, the question arises as to when and how emotional clarity contributes to greater well-being (e.g., Lischetzke & Eid, 2017) and happiness (e.g., Extremera et al., 2011). From a therapeutic perspective, this is also important because interventions that employ strategies related to meta-skills such as mindfulness, acceptance, and other strategies have commonalities with emotional clarity (Ruiz & Odriozola-González, 2015; Wells & Roussis, 2014).

Given these findings of the current study, examining the role of attention to emotion and emotional clarity from a multidimensional perspective might be more useful and informative for assessing anxiety and anxiety-comorbid depression. Otherwise, the moderating role of attention to emotion appears to be less demonstrable in the presence of anxiety symptoms (e.g., Butler et al., 2018). In addition, early screening of these dimensions of emotional self-awareness and, if appropriate, training programs may be helpful in better regulating emotions and developing necessary coping strategies. Any improvement in these dimensions may in turn contribute to the use of advanced cognitive meta-skills (i.e., emotional intelligence, emotion regulation, and mentalizing).

Limitations and future directions

In the present study, the self-report questionnaire was used to assess anxiety and depression scores. Although the General Health Questionnaire (Goldberg & Hillier, 1979) is a good screening tool and is widely used in primary care (e.g., Werneke et al., 2000), this study could have benefited even more if an interview-based assessment of anxiety and depression had also been included. Similarly, our results are helpful and informative, but we cannot infer a cause-and-effect relationship because our data represent a cross-sectional study design. Therefore, replication with a longitudinal study design could help draw more certain conclusions. In addition, it is important to note that the results of the present study cannot be generalized to other age groups or clinical populations because it is limited to adults and nonclinical populations. However, future studies could extend the findings of the present study by focusing on anxiety and depression in a sample of adolescents (e.g., Blöte & Westenberg, 2019). This is because the results could indicate different patterns of associations at different developmental stages. Finally, assessing attention to emotion and emotional clarity from this dimensional perspective could be a useful approach to better understand risk factors for the co-occurrence of anxiety and depression. Future research might therefore consider further evaluation of this hypothesis in treatment-seeking samples. This step could suggest avenues for developing adaptive and effective interventions that meet the needs of individuals.

Conclusion

The results of the current study highlight the moderating role of meta-mood knowledge by focusing on individual differences in attention to emotion and emotional clarity and finding meaningful associations of the relationship between anxiety and depression. For example, we

found that the combination of low attention and high clarity was associated with lower risk for anxiety and anxiety-comorbid depression. With this approach, we have uniquely highlighted the importance of understanding when and in whom emotional clarity is better, and whether applying this approach in practice could improve outcomes for therapeutic and preventive purposes. We hope that these findings will lead to a new research direction and challenge classic theories about the role of insight.

References

Ballespí, S., Vives, J., Alonso, N., Sharp, C., Ramírez, M. S., Fonagy, P., & Barrantes-Vidal, N. (2019). To know or not to know? Mentalization as protection from somatic complaints. *PLoS ONE*, *14*(5), 1–20. https://doi.org/10.1371/journal.pone.0215308

Bateman, A., & Fonagy, P. (2013). Mentalization-Based Treatment. *Psychoanalytic Inquiry*, *33*(6), 595–613. https://doi.org/10.1080/07351690.2013.835170

Berenbaum, H., Bredemeier, K., Thompson, R. J., & Boden, M. T. (2012). Worry, anhedonic depression, and emotional styles. *Cognitive Therapy and Research*, *36*(1), 72–80. https://doi.org/10.1007/s10608-010-9329-8

Blöte, A. W., & Westenberg, P. M. (2019). The temporal association between emotional clarity and depression symptoms in adolescents. *Journal of Adolescence*, *71*(August 2018), 110–118. https://doi.org/10.1016/j.adolescence.2019.01.005

Boden, M. T., & Thompson, R. J. (2017). Meta-Analysis of the Association between Emotional Clarity and Attention to Emotions. *Emotion Review*, *9*(1), 79–85. https://doi.org/10.1177/1754073915610640

Boden, M. T., Thompson, R. J., Dizén, M., Berenbaum, H., & Baker, J. P. (2013). Are emotional clarity and emotion differentiation related? *Cognition and Emotion*, *27*(6), 961–978. https://doi.org/10.1080/02699931.2012.751899

Butler, R. M., Boden, M. T., Olino, T. M., Morrison, A. S., Goldin, P. R., Gross, J. J., & Heimberg, R. G. (2018). Emotional clarity and attention to emotions in cognitive behavioral

group therapy and mindfulness-based stress reduction for social anxiety disorder. *Journal of Anxiety Disorders*, *55*(3), 31–38. https://doi.org/10.1016/j.janxdis.2018.03.003

Cohen, J. (1988). Statistical Power Analysis for the Behavioral Sciences. In *Statistical Power Analysis for the Behavioral Sciences* (2nd ed.). Routledge. https://doi.org/10.4324/9780203771587

Cowden, R. G., Chapman, I., & Houghtaling, A. (2021). Additive, Curvilinear, and Interactive Relations of Anxiety and Depression With Indicators of Psychosocial Functioning. *Psychological Reports*, *124*(2), 627–650. https://doi.org/10.1177/0033294120918809

Eckland, N. S., & Berenbaum, H. (2021). Emotional Awareness in Daily Life: Exploring Its Potential Role in Repetitive Thinking and Healthy Coping. *Behavior Therapy*, *52*(2), 338–349. https://doi.org/10.1016/j.beth.2020.04.010

Extremera, N., Salguero, J. M., & Fernández-Berrocal, P. (2011). Trait Meta-Mood and Subjective Happiness: A 7-week Prospective Study. *Journal of Happiness Studies*, *12*(3), 509–517. https://doi.org/10.1007/s10902-010-9233-7

Eysenck, M. W., & Fajkowska, M. (2018). Anxiety and depression: toward overlapping and distinctive features. *Cognition and Emotion*, *32*(7), 1391–1400. https://doi.org/10.1080/02699931.2017.1330255

Eysenck, M. W., Payne, S., & Santos, R. (2006). Anxiety and depression: Past, present, and future events. *Cognition and Emotion*, *20*(2), 274–294. https://doi.org/10.1080/02699930500220066

Faul, F., Erdfelder, E., Buchner, A., & Lang, A.-G. (2009). Statistical power analyses using G*Power 3.1: Tests for correlation and regression analyses. *Behavior Research Methods*, *41*(4), 1149–1160. https://doi.org/10.3758/BRM.41.4.1149

Fernández-Berrocal, P., & Extremera, N. (2008). A review of Trait Meta-Mood Research. *International Journal of Psychology Research*, *2*(1), 39–67.

Fernandez-Berrocal, P., Extremera, N., & Ramos, N. (2004). Validity and Reliability of the Spanish Modified Version of the Trait Meta-Mood Scale. *Psychological Reports*, *94*(3), 751–755. https://doi.org/10.2466/pr0.94.3.751-755

Gardner, H. (2006). *Multiple intelligences: New horizons* ((Rev. ed.)). Basic Books. https://psycnet.apa.org/record/2006-21200-000

Gohm, C. L. (2003). Mood Regulation and Emotional Intelligence: Individual Differences. *Journal of Personality and Social Psychology*, *84*(3), 594–607. https://doi.org/10.1037/0022-3514.84.3.594

Goldberg, D., & Hillier, V. (1979). A scaled version of the GHQ. *Psychological Medicine*, *9(1)*, 139–145.

Goleman, D. (1995). *Emotional intelligence*. New York, NY: Bantam Books.

Gross, J. J., & Jazaieri, H. (2014). Emotion, emotion regulation, and psychopathology: an affective science perspective. *Clinical Psychological Science*, *2*(4), 387–401. https://doi.org/10.1177/2167702614536164

Gross, J. J., & John, O. P. (2003). Individual Differences in Two Emotion Regulation Processes: Implications for Affect, Relationships, and Well-Being. *Journal of Personality and Social Psychology*, *85*(2), 348–362. https://doi.org/10.1037/0022-3514.85.2.348

Grupe, D. W., & Nitschke, J. B. (2013). Uncertainty and anticipation in anxiety: An integrated neurobiological and psychological perspective. *Nature Reviews Neuroscience*, *14*(7), 488–501. https://doi.org/10.1038/nrn3524

Hayes, A. F. (2018). *Introduction to mediation, moderation, and conditional process analysis: A regression-based approach* (Second edition). New York, NY: Guilford Press.

Hirschfeld, R. M. A. (2001). The comorbidity of major depression and anxiety disorders: Recognition and management in primary care. *Primary Care Companion to the Journal of Clinical Psychiatry*, *3*(6), 244–254. https://doi.org/10.4088/pcc.v03n0609

Kerns, J. G., & Berenbaum, H. (2010). Affective processing in overwhelmed individuals: Strategic and task considerations. *Cognition and Emotion*, *24*(4), 638–660. https://doi.org/10.1080/02699930902927664

Kessler, R. C., Sampson, N. A., Berglund, P., Gruber, M. J., Al-Hamzawi, A., Andrade, L., Bunting, B., Demyttenaere, K., Florescu, S., De Girolamo, G., Gureje, O., He, Y., Hu, C., Huang, Y., Karam, E., Kovess-Masfety, V., Lee, S., Levinson, D., Medina Mora, M. E., … Wilcox, M. A. (2015). Anxious and non-anxious major depressive disorder in the World Health Organization World Mental Health Surveys. *Epidemiology and Psychiatric Sciences*, *24*(3), 210–226. https://doi.org/10.1017/S2045796015000189

Kessler, R. C., Aguilar-Gaxiola, S., Alonso, J., Chatterji, S., Lee, S., Ormel, J., Üstün, T. B., & Wang, P. S. (2009). The global burden of mental disorders: An update from the WHO World Mental Health (WMH) Surveys. *Epidemiologia e Psichiatria Sociale*, *18*(1), 23–33. https://doi.org/10.1017/S1121189X00001421

Lamers, F., Van Oppen, P., Comijs, H. C., Smit, J. H., Spinhoven, P., Van Balkom, A. J. L. M., Nolen, W. A., Zitman, F. G., Beekman, A. T. F., & Penninx, B. W. J. H. (2011). Comorbidity patterns of anxiety and depressive disorders in a large cohort study: The Netherlands Study of Depression and Anxiety (NESDA). *Journal of Clinical Psychiatry*, *72*(3), 342–348. https://doi.org/10.4088/JCP.10m06176blu

Lischetzke, T., & Eid, M. (2017). The functionality of emotional clarity: A process-oriented approach to understanding the relation between emotional clarity and well-being. In *The Happy Mind: Cognitive Contributions to Well-Being* (pp. 371–388). Springer International Publishing. https://doi.org/10.1007/978-3-319-58763-9_20

Lobo, A., Pérez-Echeverría, M. J., & Artal, J. (1986). Validity of the scaled version of the General Health Questionnaire (GHQ-28) in a Spanish population. *Psychological Medicine*, *16*(1), 135–140. https://doi.org/10.1017/S0033291700002579

Luyten, P., Campbell, C., Allison, E., & Fonagy, P. (2020). The Mentalizing Approach to Psychopathology: State of the Art and Future Directions. *Annual Review of Clinical Psychology*, *16*, 297–325. https://doi.org/10.1146/annurev-clinpsy-071919-015355

Park, J., & Naragon-Gainey, K. (2019). Daily experiences of emotional clarity and their

association with internalizing symptoms in naturalistic settings. *Emotion*, *19*(5), 764–775.

https://doi.org/10.1037/emo0000482

Ruiz, F. J., & Odriozola-González, P. (2015). Comparing Cognitive, Metacognitive, and

Acceptance and Commitment Therapy Models of Depression: a Longitudinal Study Survey.

The Spanish Journal of Psychology, *18*, E39. https://doi.org/10.1017/sjp.2015.31

Salovey, P., Mayer, J. D., Goldman, S. L., Turvey, C., & Palfai, T. P. (1995). Emotional

attention, clarity, and repair: Exploring emotional intelligence using the Trait Meta-Mood

Scale. In *emotion, disclosure, & health.* American Psychological Association.

https://doi.org/10.1037/10182-006

Starr, L. R., & Davila, J. (2012a). Temporal patterns of anxious and depressed mood in

generalized anxiety disorder: A daily diary study. *Behaviour Research and Therapy*, *50*(2),

131–141. https://doi.org/10.1016/j.brat.2011.11.005

Starr, L. R., & Davila, J. (2012b). Cognitive and interpersonal moderators of daily co-occurrence

of anxious and depressed moods in generalized anxiety disorder. *Cognitive Therapy and

Research*, *36*(6), 655–669. https://doi.org/10.1007/s10608-011-9434-3

Thompson, R. J., Mata, J., Jaeggi, S. M., Buschkuehl, M., Jonides, J., & Gotlib, I. H. (2011).

Concurrent and prospective relations between attention to emotion and affect intensity: An

experience sampling study. *Emotion*, *11*(6), 1489–1494. https://doi.org/10.1037/a0022822

Thompson, R. J., Mata, J., Jaeggi, S. M., Buschkuehl, M., Jonides, J., & Gotlib, I. H. (2013). The Role of Attention to Emotion in Recovery from Major Depressive Disorder. *Depression Research and Treatment*, *2013*, 1–6. https://doi.org/10.1155/2013/540726

Vine, V., & Aldao, A. (2014). Impaired emotional clarity and psychopathology: A transdiagnostic deficit with symptom-specific pathways through emotion regulation. *Journal of Social and Clinical Psychology*, *33*(4), 319–342. https://doi.org/10.1521/jscp.2014.33.4.319

Vives, J., Morales, C., Barrantes-Vidal, N., & Ballespí, S. (2021). Emotional comprehension is not related to duration of distress from daily life events. *International Journal of Environmental Research and Public Health*, *18*(2), 1–10. https://doi.org/10.3390/ijerph18020459

Wells, A., & Roussis, P. (2014). Refraining from intrusive thoughts is strategy dependent: A comment on Sugiura, et al. and a preliminary informal test of detached mindfulness, acceptance, and other strategies. *Psychological Reports*, *115*(2), 541–544. https://doi.org/10.2466/02.PR0.115c21z9

Werneke, U., Goldberg, D. P., Yalcin, I., & Üstün, B. T. (2000). The stability of the factor structure of the general health questionnaire. *Psychological Medicine*, *30*(4), 823–829. https://doi.org/10.1017/S0033291799002287

WHO. (2021). Mental health in emergencies. *World Health Organization.* https://www.who.int/news-room/fact-sheets/detail/mental-health-in-emergencies

WHO. (2017). Depression and other common mental disorders Global: health estimates. In

World Health Organization (pp. 1-24).

http://apps.who.int/iris/bitstream/10665/254610/1/WHO-MSD-MER-2017.2-eng.pdf?ua=1

Table 1. Descriptive statistics and Pearson correlation coefficients for the study variables

	M (*SD*)	Skewness	Kurtosis	1	2	3	4
1.Anxiety	3.87 (2.08)	-0.126	-0.952	1			
2.Depression	0.90 (1.50)	2.195	4.981	.496**	1		
3.Attention	22.26 (6.01)	0.243	-0.154	.136*	.116	1	
4.Clarity	28 (6.23)	-0.236	-0.273	-.217**	-.223**	.330*	1

Note. *N* = 255. *M* = Mean. *SD* = Standard deviation.

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

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

Table 2. Conditional main and interaction effects on depression

	b	*p*	95 % CI
Constant	0.80	*p* < .001	[0.62, 0.98]
Anxiety	0.32	*p* < .001	[0.25, 0.40]
Attention to emotion	0.03	*p* = .061	[-0.00, 0.06]
Emotional clarity	-0.04	*p = .010*	[-0.07, -0.01]
Anxiety x EA	0.02	*p = .013*	[0.00, 0.03]
Anxiety x EC	-0.02	*p = .003*	[-0.03, -0.01]

Note. EA = Attention to emotion; EC = Emotional clarity.

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

Table 3. At low and high percentiles of the moderator variables

	b	*p*	95 % CI
High EA - low EC	0.54	*p* < .001	[0.37, 0.71]
Low EA - low EC	0.32	*p* < .001	[0.18, 0.46]
High EA - high EC	0.32	*p* < .001	[0.18, 0.46]
Low EA - high EC	0.10	*p* = .121	[-0.03, 0.23]

Note. Moderator variables: EA = Attention to emotion; EC = Emotional clarity

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

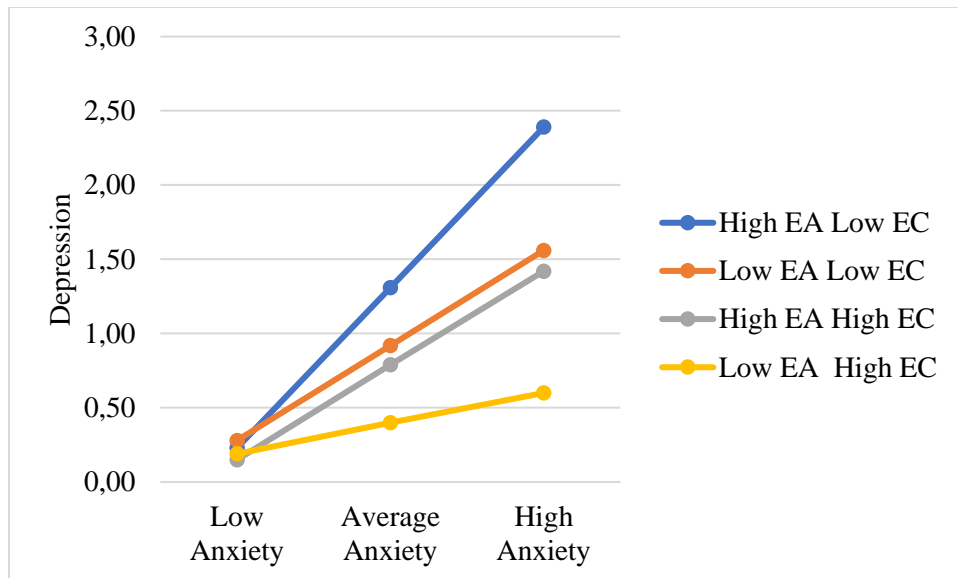Low = Individuals who scored in or below the 16th percentile.

Figure 1. Interaction plot for attention to emotion and emotional clarity

Note. EA = Attention to emotion; EC = Emotional clarity

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

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