

# *Associations between interpretation bias and depression in adolescents*

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## **Abstract**

Interpretation biases have been shown to play a role in adult depression and are a target in cognitive behavioural therapy. Adolescence is a key risk period for the development of depression and a period of rapid cognitive and emotional development but little research has investigated the relationship between interpretation biases and depression in adolescents. This study adapted a measure of interpretation bias, the Ambiguous Scenarios Test for Depression, for adolescents and evaluated its reliability and validity. A community sample of 206 young people aged 12 to 18 years completed a validated measure of depression symptoms (Mood and Feelings Questionnaires) and the adapted Ambiguous Scenarios Test. The Ambiguous Scenarios Test for Depression in Adolescents had good internal consistency and split half reliability. Depression symptoms were associated with participants' ratings of the valence of ambiguous situations and with interpretation biases. Importantly, symptoms of depression and anxiety were independently associated with interpretation bias. This research suggests that interpretation biases can be measured in this age group, that negative interpretation biases exist in adolescents and that these are associated with depression symptoms.

Cognitive models of emotional disorders suggest that information processing is biased in anxiety and depression (Mathews & MacLeod, 2005). A key element of information processing is the interpretation of ambiguous information. Individuals with anxiety disorders interpret ambiguous information as threatening and the interpretation is typically specific to the type of anxiety disorder, e.g. social threat, physical threat (Richards, Austin, & Alvarenga, 2001; Voncken, Bögels, & de Vries, 2003). Research investigating interpretation bias in depression is in its early stages (Gotlib & Joormann, 2010) but ‘offline’ self-report methods and ‘online’ response latency methods, suggest that, depression in adults is associated with negatively biased interpretation of ambiguous information (Butler & Mathews, 1983; Lawson, MacLeod, & Hammond, 2002; Rude, Wenzlaff, Gibbs, Vane, & Whitney, 2002).

Cognitive behavioural therapy (CBT), a treatment recommended for depression in adults and adolescents (e.g. APA, 2010; NICE, 2005, 2009) includes targeting interpretation biases as a core technique. It is generally assumed that the cognitive model of depression applies to adolescents and thus that they will also exhibit negative cognitive biases. However, CBT appears to be less effective with depressed adolescents than with adults (e.g. Weisz, McCarty, & Valeri, 2006). There are many possible reasons for this but one plausible explanation is that the cognitive model of depression may not be directly transferrable to this group. During adolescence, cognitive and emotional development is ongoing; adolescents do not have the same cognitive ‘architecture’ as adults (e.g. Pfeifer & Blakemore, 2012) and therefore direct comparisons may not be valid. Interpretation biases have been reported in anxious adolescents (Miers, Blöte, Bögels, & Westenberg, 2008; Waite, Codd, & Creswell, 2015). However, cognitive and neural processing of anxiety and depression during adolescence shows both overlaps and differences (e.g. Beesdo et al., 2009; Etkin &

Schatzberg, 2011; Thomas et al., 2001), with some evidence that cognitions associated with anxiety emerge before those associated with depression.

There is limited evidence that interpretation biases are associated specifically with depression and low mood in adolescents. Dearing and Gotlib (2009) assessed interpretation bias in daughters of women with recurrent depression. Participants completed two interpretation bias tasks. In the first of these tasks, participants listened to ambiguous auditory stimuli (acoustic blends of neutral words combined with positive words e.g. joy-boy, or negative words e.g. sad-sand), then selected the word they thought they heard. In the second task, participants were presented with ambiguous stories that remained ambiguous until the final word resolved the ambiguity. Participants were instructed to indicate with a key press that the final word was grammatically correct. Response latencies to the key press were recorded. Following a negative mood induction, girls with depressed mothers made more negative interpretations on both tasks than a control group of girls who had mothers with no depression. Haley et al. (1985) presented four possible outcomes to ambiguous vignettes to children and adolescents with and without a depressive disorder. Depressed participants were more likely to choose the most negatively biased outcomes. Recent work has also started investigating the use of a cognitive bias modification (CBM) paradigm in adolescent depression. Research has investigated CBM with healthy participants (Lothmann, Holmes, Chan, & Lau, 2011) and with participants with mild depression (Micco, Henin, & Hirshfeld-Becker, 2014). Both studies found that positive CBM training reduced negative interpretation biases. However, only Lothmann et al. (2011) found that this change in interpretation translated to decreased negative affect.

The standard method of measuring interpretation biases has been established in relation to anxiety disorders using responses to ambiguous scenarios (Butler & Mathews,

1983). Berna and colleagues (2011) adapted this to create the Ambiguous Scenarios Test for Depression (AST-D). Their measure includes 24 scenarios, for example, ‘You join a tennis club and before long you are asked to play in a doubles match. It's a tough match and afterwards you discuss your performance with your partner.’ Berna et al. (2011) asked participants to imagine an outcome for each scenario and to rate the pleasantness of each imagined outcome. Outcomes were also coded as positive, negative or neutral interpretations. Symptoms of depression were positively correlated with the number of negative interpretations, and negatively correlated with the number of positive interpretations and pleasantness ratings. Pleasantness ratings and interpretations distinguished between high and low dysphoric participants. The AST-D predicts future depressive symptoms in adults (Kleim, Thörn, & Ehlert, 2014), and a reduction in negative interpretations, as measured by the pleasantness ratings of the AST-D, was associated with reductions in symptoms of depression (Williams, Blackwell, Mackenzie, Holmes, & Andrews, 2013).

We adapted the Ambiguous Scenarios Test for Depression (Berna et al., 2011) so that the content was appropriate for adolescents. We therefore assessed the suitability and psychometric qualities of this adapted measure with adolescents aged 12 to 18 years. Importantly we also examined the strength of the association between depression and interpretation bias, independently of anxiety symptoms. Anxiety and depression frequently co-occur in both adults and depression and interpretation biases are a well-established feature of anxiety. It is therefore possible that any observed link between interpretation biases and low mood is an artefact of the high co-morbidity of anxiety and depression rather than a specific feature of depression.

Based on theory and previous research, the following hypotheses were examined:

1. Depression and anxiety symptoms will significantly predict adolescents' ratings of ambiguous scenarios. Higher symptoms of depression and anxiety will be associated with more negative interpretations and lower pleasantness ratings.
2. Depression symptoms will be a significant and independent predictor of interpretation bias and pleasantness after controlling for anxiety.

## **Materials and Methods**

### **Participants**

Two hundred and six adolescents, aged 12-18 years, participated in the study. The majority of the sample completed the study in groups in their school classroom (N = 169); 37 were tested individually either in the laboratory or at home depending on their preference.

To gain access to schools, letters were sent to the head teachers requesting permission to conduct an experiment at the school. Once approval was obtained, information packs were provided for adolescents and parents describing the study and its purpose. Adolescents who participated in the laboratory and at home were recruited through flyers. Parents of adolescents under 16 years of age provided written informed consent prior to their child's participation in the experiment. All children under 16 years gave assent and young people aged 16 years and over gave consent.

### **Procedure**

The study was approved by the University of Reading Research Ethics Committee. Research was conducted in the presence of a researcher. Participants completed self-report measures of depression and anxiety and then completed the ambiguous scenarios questionnaire.

## Measures

### Symptom Questionnaires.

***Mood and Feelings Questionnaire (MFQ; E. Costello & Angold, 1988).*** The MFQ is a 33 item self-report measure of depression symptoms with good psychometric properties (Burleson Daviss et al., 2006). Each symptom is rated on a 3 point scale from 0 (*not true*) to 2 (*true*). Internal consistency in this sample was excellent (George & Mallery, 2003; MFQ  $\alpha = .94$ ). ***Revised Child Anxiety and Depression Scale (RCADS; Chorpita, Yim, Moffitt, Umemoto, & Francis, 2000).*** The RCADS Total Anxiety subscale (37 items) was used to assess anxiety symptoms. The RCADS has good construct validity (Chorpita et al., 2000), and the Total Anxiety subscale had excellent internal consistency (George & Mallery, 2003; RCADS-Total Anxiety  $\alpha = 0.96$ ). The Major Depression subscale of the RCADS (10 items) was also administered. It was used to examine the psychometric properties of the adapted Ambiguous Scenarios Test (see below) but not in the analyses of the main hypotheses for which the MFQ was the primary measure of depression. The RCADS Major Depression subscale has excellent internal consistency (George & Mallery, 2003; RCADS-Major Depression  $\alpha = 0.90$ ).

### **Ambiguous Scenarios Test for Depression in Adolescents (AST-DA).**

Adolescents completed an adapted version of the Ambiguous Scenarios Test for Depression (AST-D; Berna et al., 2011). The original questionnaire included 24 items. Eleven items were retained and unchanged, 7 items were adapted to be more appropriate for adolescents e.g. ‘an office party’ was changed to ‘a prom party’; 4 items could not easily be adapted without significantly changing the meaning so were removed; 1 adolescent relevant item was added; 2 items were combined into a single item. The adapted version of the AST therefore had 20 items. The adapted questionnaire (with new and amended items) was



informally piloted with 12 adolescents of a variety of ages, to ensure that the content and the task demands were age appropriate.

Each item consisted of a scenario (e.g. ‘You have recently taken an important exam. Your results arrive with an unexpected letter of explanation about your grade’). Participants were instructed to (a) rate the scenario for pleasantness (from 1 = *Not at all pleasant*; to 9 = *Very pleasant*) and (b) give a written description of their imagined outcome of the situation. There was no time limit for completion. A mean pleasantness rating across the scenarios was calculated for each participant. Interpretation bias was calculated by coding each open-ended response into one of four categories. Three were based on Berna et al., (2011): ‘positive’ (e.g., ‘I got the highest mark in the exam’); ‘negative’ (e.g., ‘I failed the exam’); and ‘neutral’ if the response did not include an emotive outcome (e.g., ‘The letter tells me what grade I got’). An additional ‘mixed’ category was added; if answers included both positive and negative ideas (e.g., ‘I got the mark I needed but didn’t do as well as I had hoped’). All scenarios were rated blind to MFQ and RCADS scores. Two independent raters were trained to score responses through reading the coding scheme, verbal instruction and participating in consensus discussions. Discrepancies were handled during the training process and raters always reached agreement. Once training was completed, 10% of the sample ( $N = 20$ ) was double-rated and inter-rater reliability was assessed on these responses. Inter-rater reliability was excellent (Landis & Koch, 1977;  $\kappa = .89$ ). The independent raters then separately coded the rest of the data. For each participant, a proportion score was created for each of the four categories (positive, negative, mixed, neutral) across the scenarios.

## **Results**

### **Data Analysis**

Fourteen adolescents were excluded from the final sample for having substantial missing data (more than 25% missing) on the MFQ ( $n = 8$ ) or on the ambiguous scenarios questionnaire ( $n = 9$ ) resulting in a sample of  $N = 192$  in the final analysis. Preliminary data analysis of the association between mood, anxiety and interpretive biases found no differences between adolescents tested at school, in the laboratory or at home so they were combined throughout.

Each adolescent gave one interpretation for each scenario. All responses were codable into the four categories. Across all participants, 43% of scenarios were coded as positive, 38% as negative, 11% mixed and 9% neutral. There was no significant correlation between mixed responses and neutral responses with symptoms of depression or anxiety, so results focus only on positive and negative interpretations. To measure interpretation bias, a difference score for each participant was computed by taking the proportion of their negative interpretations away from the proportion of their positive responses. This method of calculation accommodates the existence of neutral and mixed responses, but is equivalent to assigning them a bias value of 0. Therefore a positive value indicated a positive interpretation bias and a negative value indicated a negative interpretation bias, with zero indicating no bias in either direction. A participant who responded to every scenario with a positive interpretation would have a bias score of 1.0 and a participant who responded to every scenario with a negative interpretation would have a bias score of -1.0.

The distributions of depression and anxiety symptoms were positively skewed. These variables were successfully transformed using square root transformations, and analyses were conducted with the transformed variables. Confirmatory analyses were conducted by running analyses with 1,000 bootstrap samples. All results were consistent, so original analyses with transformed variables are reported.

## **Psychometric Properties of the AST-DA**

The AST-DA had good internal consistency on pleasantness ratings (Cronbach's  $\alpha = .83$ , George & Mallery, 2003) and excellent split half reliability ( $r = .80$ ). There was good construct validity of the coded responses of interpretation bias; participants' pleasantness ratings of scenarios' were significantly positively correlated with interpretation bias scores ( $r = .79$ ). Pleasantness ratings were normally distributed (Kolmogorov-Smirnov:  $D = 0.99$ ,  $p = .20$ ) and were not correlated with age. There was a significant difference between gender on pleasantness ratings ( $t(191) = -3.88$ ,  $p < .001$ ); girls had significantly lower pleasantness ratings than boys. This was expected because female participants also reported higher levels of depression symptoms ( $t(194) = 3.52$ ,  $p = .001$ ) and anxiety symptoms ( $t(200) = 6.71$ ,  $p < .001$ ), similar to many other studies (e.g. Angold, Erkanli, Silberg, Eaves, & Costello, 2002; E. J. Costello et al., 1996).

## **Descriptive Statistics**

Sample characteristics are presented in Table 1. Mean MFQ scores were slightly higher than non-depressed norms for young people ( $M = 12$ ; Burleson Daviss et al., 2006), but much lower than in young people with current Major Depressive Disorder ( $M = 33$ ; Burleson Daviss et al., 2006). Mean RCADS total anxiety scores were similar to those seen by young people experiencing an anxiety disorders ( $M = 33$ ; Chorpita, Moffitt, & Gray, 2005) and higher than those without an anxiety disorder ( $M = 22$ ; Chorpita et al., 2005). Standard deviations of both depression and anxiety scores suggest that a wide range of scores were reported by participants.

The approximately equal proportions of positive (42%) and negative (37%) interpretations in the sample as a whole is reflected in the interpretation bias difference score ( $M = .05$ ).

Inter-correlations between variables are presented in Table 2. As expected, depression and anxiety measures were positively correlated, and pleasantness ratings for the scenarios were negatively correlated with depression and anxiety symptoms. Also consistent with expectations, interpretation bias was negatively correlated with depression and anxiety symptoms. Age was not significantly correlated with symptoms of depression and anxiety, pleasantness ratings or interpretation bias.

### **Hypothesis Testing**

To test the hypotheses that interpretation bias would be associated with depression independently of the relationship between anxiety and interpretation bias, and irrespective of gender, forced entry three step multiple regression models were conducted. As depression and anxiety symptoms were highly inter-correlated, collinearity statistics were consulted and results met the required assumptions (max. VIF = 2.37, min. Tolerance = .42).

#### **Association of depression and anxiety with pleasantness ratings**

The individual contribution of anxiety and depression symptoms on pleasantness ratings was examined in a forced entry multiple regression model. Gender was associated with anxiety and depression symptoms; therefore gender, depression and anxiety scores were entered as predictor variables with pleasantness as the dependent variable. The overall equation for the prediction of pleasantness ratings was significant,  $F(3,184) = 24.99, p < .001, R^2 = .29$ . Gender did not independently predict pleasantness ratings ( $B = .10, t(184) = 1.50, p = .14$ ). Anxiety ( $B = -.32, t(184) = -3.35, p = .001$ ) and depression symptom scores ( $B = -.21, t(184) = -2.32, p = .021$ ) were independent predictors of pleasantness ratings of ambiguous scenarios.

#### **Association of depression and anxiety with interpretation bias**

To assess the individual contribution of anxiety and depression symptoms on interpretation bias, gender, anxiety and depression scores were entered in a forced entry multiple regression model. The overall equation for the prediction of interpretation bias was significant,  $F(3,185) = 39.06, p < .001, R^2 = .39$ . Gender did not independently predict interpretation bias ( $B = .04, t(185) = .56, p = .57$ ). Anxiety ( $B = -.44, t(185) = -4.93, p < .001$ ) and depression symptom scores ( $B = -.21, t(185) = -2.56, p = .011$ ) were independent predictors of interpretation bias.

### **Discussion**

According to the cognitive model of depression, information processing errors, including a negative interpretation bias, contribute to the development and maintainance of depression and anxiety. Based on this, cognitive behaviour therapy for depression involves identifying and modifying cognitive biases, including negative interpretation biases. Despite this, the hypothesis that interpretation biases are associated with depression has rarely been tested in adult or adolescents. It is important to test the model in adolescents, separately from adults, because cognitive and emotional processing and the neural structures that organise and integrate cognition and emotion develop rapidly during this period of life. For this reason it cannot be assumed that cognitions that are identified in adult samples will also be identified amongst adolescents.

In this study we adapted a measure of depressive interpretation bias (Berna et al., 2011) so that it was suitable for adolescents. In a sample of adolescents recruited from the community, the adapted measure of ambiguous scenarios was internally consistent, had good inter-rater reliability and appeared to have construct validity. The sample included young people with symptoms that were similar in severity to those in a clinical population (81 participants had anxiety scores similar to those with an anxiety disorder and 45 participants

had depression scores similar to those with depressive disorder). However, the presence of clinical depression and/or anxiety diagnoses was not assessed so the proportion of the sample who would have met formal diagnostic criteria is unknown. It is important therefore to validate the AST-DA in a clinical sample of adolescents. Ideally this would identify a difference in interpretation biases between clinically depressed adolescents and healthy control adolescents.

We tested the hypothesis that a negative interpretation bias is associated with depression in adolescents, and that this relationship is independent of co-occurring anxiety symptoms. There was a moderate association between depression symptoms and interpretation bias, even after controlling for anxiety symptoms. Young people with elevated symptoms of depression (and/or anxiety) were significantly more likely to interpret ambiguous scenarios as negative than as positive. These data therefore suggest that a core element of the cognitive model of depression does apply to adolescents. A gender difference was found for scores on the AST-DA, however, we were unable to explore this further as the male and female groups were not matched in the current sample. The interaction between gender and depressive symptoms on bias scores would be interesting for future work to address. There was no association between interpretation bias and age. The mean age of participants in this study was 16 years and further investigation of how and when interpretation biases emerge would be valuable.

This was a cross sectional study and thus it cannot be assumed that interpretation biases lead to depression. Ideally a longitudinal study of adolescents recruited at a younger age would clarify both the causal direction of the relationship between bias and depression and identify when interpretation biases begin to emerge. This research has a number of implications for developmental psychopathology research. It shows that adolescents make

interpretation biases (both negative and positive) and that these are associated with symptoms of depression. It suggests that the cognitive model of depression is relevant to adolescents, at least in the area of interpretation biases. It also provides a tool to assess interpretation biases in adolescents. This may be of value in research on cognitive bias modification in adolescents, either as a pre- and post-treatment assessment tool, or as standardised stimuli that could be used in treatment (Chan et al., 2015).

### **Conclusion**

Interpretation biases can be measured in adolescents and are associated independently with depression and anxiety symptoms, suggesting that this core element of the cognitive model of depression does apply to adolescents. The direction of causality has not been reliably established and we do not know at what age the biases develop and emerge.

## **Disclosures**

Faith Orchard, Laura Pass and Shirley Reynolds have no conflicts of interest. All procedures followed were in accordance with ethical standards of the responsible committee on human experimentation (national and institutional). Informed consent was obtained from all individual subjects participating in the study. No animal studies were carried out by authors for this paper.



## References

- Angold, A., Erkanli, A., Silberg, J., Eaves, L., & Costello, E. (2002). Depression scale scores in 8-17-year-olds: Effects of age and gender. *Journal of Child Psychology and Psychiatry*, *43*(8), 1052-1063.
- APA. (2010). *Publication Manual of the American Psychological Association (6th ed.)*. Washington, DC: American Psychological Association.
- Beesdo, K., Lau, J. Y., Guyer, A. E., McClure-Tone, E. B., Monk, C. S., Nelson, E. E., . . . Leibenluft, E. (2009). Common and distinct amygdala-function perturbations in depressed vs anxious adolescents. *Archives of General Psychiatry*, *66*(3), 275-285.
- Berna, C., Lang, T., Goodwin, G., & Holmes, E. (2011). Developing a measure of interpretation bias for depressed mood: An ambiguous scenarios test. *Personality and Individual Differences*, *51*(3), 349-354.
- Burleson Daviss, W., Birmaher, B., Melhem, N., Axelson, D., Michaels, S., & Brent, D. (2006). Criterion validity of the Mood and Feelings Questionnaire for depressive episodes in clinic and non-clinic subjects. *Journal of Child Psychology and Psychiatry*, *47*(9), 927-934.
- Butler, G., & Mathews, A. (1983). Cognitive processes in anxiety. *Advances in Behaviour Research and Therapy*, *5*(1), 51-62.
- Chorpita, B., Moffitt, C., & Gray, J. (2005). Psychometric properties of the Revised Child Anxiety and Depression Scale in a clinical sample. *Behaviour Research and Therapy*, *43*(3), 309-322.

- Chorpita, B., Yim, L., Moffitt, C., Umemoto, L., & Francis, S. (2000). Assessment of symptoms of DSM-IV anxiety and depression in children: A revised child and adolescent depression scale. *Behaviour Research and Therapy*, 38(8), 835-855.
- Costello, E., & Angold, A. (1988). Scales to assess child and adolescent depression: checklists, screens, and nets. *Journal of the American Academy of Child & Adolescent Psychiatry*, 27(6), 726-737.
- Costello, E. J., Angold, A., Burns, B. J., Stangl, D. K., Tweed, D. L., Erkanli, A., & Worthman, C. M. (1996). The Great Smoky Mountains Study of Youth: goals, design, methods, and the prevalence of DSM-III-R disorders. *Archives of General Psychiatry*, 53(12), 1129-1136.
- Dearing, K., & Gotlib, I. (2009). Interpretation of ambiguous information in girls at risk for depression. *Journal of Abnormal Child Psychology*, 37(1), 79-91.
- Etkin, A., & Schatzberg, A. F. (2011). Common abnormalities and disorder-specific compensation during implicit regulation of emotional processing in generalized anxiety and major depressive disorders. *American Journal of Psychiatry*, 168(9), 968 - 978.
- George, D., & Mallery, M. (2003). Using SPSS for Windows step by step: a simple guide and reference. *Boston, MA: Allyn y Bacon.[Links]*.
- Gotlib, I., & Joormann, J. (2010). Cognition and depression: current status and future directions. *Annual Review of Clinical Psychology*, 6, 285-312.

- Haley, G., Moretti, M., & Freeman, R. (1985). Cognitive bias and depression in psychiatrically disturbed children and adolescents. *Journal of Consulting Clinical Psychology, 53*(4), 535-537.
- Kleim, B., Thörn, H. A., & Ehlert, U. (2014). Positive interpretation bias predicts well-being in medical interns. *Frontiers in Psychology, 5*. doi: 10.3389/fpsyg.2014.00640
- Landis, J. R., & Koch, G. G. (1977). The measurement of observer agreement for categorical data. *Biometrics, 33*(1), 159-174.
- Lawson, C., MacLeod, C., & Hammond, G. (2002). Interpretation revealed in the blink of an eye: Depressive bias in the resolution of ambiguity. *Journal of Abnormal Psychology, 111*(2), 321-328.
- Mathews, A., & MacLeod, C. (2005). Cognitive vulnerability to emotional disorders. *Annual Review of Clinical Psychology, 1*, 167-195.
- Miers, A. C., Blöte, A. W., Bögels, S. M., & Westenberg, P. M. (2008). Interpretation bias and social anxiety in adolescents. *Journal of Anxiety Disorders, 22*(8), 1462-1471.
- NICE. (2005). *Depression in children and young people: Identification and management in primary, community and secondary care (CG28)*. London, UK: National Institute for Health and Care Excellence.
- NICE. (2009). *Depression in adults: The treatment and management of depression in adults*. London, UK: National Institute for Health and Care Excellence.

- Pfeifer, J. H., & Blakemore, S.-J. (2012). Adolescent social cognitive and affective neuroscience: past, present, and future. *Social Cognitive and Affective Neuroscience*, 7(1), 1-10.
- Richards, J. C., Austin, D. W., & Alvarenga, M. E. (2001). Interpretation of ambiguous interoceptive stimuli in panic disorder and nonclinical panic. *Cognitive Therapy and Research*, 25(3), 235-246.
- Rude, S. S., Wenzlaff, R. M., Gibbs, B., Vane, J., & Whitney, T. (2002). Negative processing biases predict subsequent depressive symptoms. *Cognition and Emotion*, 16(3), 423-440.
- Thomas, K. M., Drevets, W. C., Dahl, R. E., Ryan, N. D., Birmaher, B., Eccard, C. H., . . . Casey, B. (2001). Amygdala response to fearful faces in anxious and depressed children. *Archives of General Psychiatry*, 58(11), 1057-1063.
- Voncken, M. J., Bögels, S. M., & de Vries, K. (2003). Interpretation and judgmental biases in social phobia. *Behaviour Research and Therapy*, 41(12), 1481-1488.
- Waite, P., Codd, J., & Creswell, C. (2015). Interpretation of ambiguity: Differences between children and adolescents with and without an anxiety disorder. *Journal of Affective Disorders*, 188, 194-201.
- Weisz, J., McCarty, C., & Valeri, S. (2006). Effects of psychotherapy for depression in children and adolescents: a meta-analysis. *Psychological Bulletin*, 132(1), 132-149.
- Williams, A., Blackwell, S., Mackenzie, A., Holmes, E., & Andrews, G. (2013). Combining imagination and reason in the treatment of depression: A randomised controlled trial

of internet-based cognitive-bias modification and internet-CBT for depression.

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**Table 1.** Sample Characteristics

(Mean, <i>SD</i> , range)	N = 192
Age	16.06 (1.21) [12.48 – 18.61]
Gender (percent female)	66%
MFQ	17.98 (12.77) [0 – 59]
RCADS Total Anxiety	31.75 (19.87) [0 – 99]
RCADS Major Depression	8.58 (5.90) [0 – 28]
Pleasantness Ratings	5.46 (1.05) [2.65 – 9.00]
Interpretation Bias	0.05 (0.33) [-.75 – .85]

*Note.* *MFQ*: Mood and Feelings Questionnaire; *RCADS*: Revised Child Anxiety and Depression Scale; *Pleasantness Ratings*: Mean Pleasantness Ratings; *Interpretation Bias*: Interpretation Bias Difference Score.

**Table 2.** Inter-correlations between the Measures.

	MFQ	RCADS-Anx	Age	Pleasantness	Interpretation	Positive	Negative	Neutral
RCADS-Anx	.73*							
Age	.08	.14						
Pleasantness	-.47*	-.50*	-.05					
Interpretation	-.54*	-.59*	.09	.79*				
Positive	-.45*	-.52*	.10	.70*	.94*			
Negative	.56*	.58*	-.06	-.78*	-.94*	-.77*		
Neutral	-.15	-.16	-.18	.15	-.03	-.26*	-.20	
Mixed	-.10	.01	.12	.07	.12	-.12	-.33*	-.11

*Note.* MFQ: Mood and Feelings Questionnaire; RCADS-Anx: Revised Child Anxiety and Depression Scale – Total Anxiety Score; Pleasantness: Mean Pleasantness Ratings; Interpretation: Interpretation Bias Difference Score; Positive: Positive Interpretations; Negative: Negative Interpretations; Neutral: Neutral Interpretations; Mixed: Mixed Interpretations

\* $p < .001$