



An examination of generalized anxiety disorder and dysthymia utilizing the Rorschach inkblot method



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ABSTRACT

This study examined transdiagnostic features of generalized anxiety disorder (GAD) and dysthymia in an outpatient clinical sample. Fifteen patients who met DSM-IV criteria for GAD and twenty-one patients who met DSM-IV criteria for dysthymia but who did not have comorbid anxiety disorder were evaluated utilizing the Rorschach. Salient clinical variables were then compared. Results showed that patients with GAD scored significantly higher on variables related to cognitive agitation and a desire/need for external soothing. In addition, there was a trend for patients with GAD to produce higher scores on a measure of ruminative focus on negative aspects of the self. Thus, not surprisingly, GAD patients' experienced more distress than the dysthymic patients. The implications of these findings are discussed with regards to better understanding the shared and distinct features of GAD and dysthymia.

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1. Introduction

Anxiety disorders are highly comorbid with many mental disorders, especially mood disorders (Goldberg and Fawcett, 2012). This is not surprising given that anxiety and efforts to dispel anxiety are often believed to underlie emotional distress (Wachtel, 2011). Thus, the comorbidity between anxiety and mood disorders is increasingly seen as reflecting meaningful covariation that arises out of common underlying structures (Krueger, 1999; Blais, 2010; Lahey et al., 2012). The specific shared mechanisms believed to play a role in the development and maintenance of anxiety and depression are often referred to as transdiagnostic factors (Nolen-Hoeksema and Watkins, 2011). The identification of these factors has relevance for improving theoretical models of disorders and informing treatment. Therefore, possible transdiagnostic features of highly comorbid disorders such as generalized anxiety disorder (GAD) and dysthymia have become an important focus of research.

Transdiagnostic factors associated with anxiety and depression tend to fall under a broader umbrella of internalizing negative affect and problems in emotion regulation (Mennin et al., 2007; Kotov et al., 2011). Specifically, research indicates that individuals

with anxiety and depression share the following transdiagnostic factors: feelings of sadness and helplessness, impaired ability to repair negative moods, and rumination (Salovey et al., 2002; Mennin et al., 2007; McEvoy et al., 2013; Yang et al., 2014).

Importantly, the specific manifestation of these factors may differ in anxiety and depression. For example, while sadness and helplessness occur with both anxiety and depression, they tend to be more pronounced in depression (Miranda and Mennin, 2007; Mennin et al., 2007). Thus, it has been theorized that the stronger prevalence of these factors leads people who are depressed to make less efforts to repair negative moods because they see the effort as futile or they lack the energy/motivation to do so (Mennin et al., 2007). In contrast, anxiety typically causes emotional arousal and doubt about one's ability to cope with negative events (Mennin et al., 2007; Robichaud, 2013). Thus, anxious individuals are more likely to seek reassurance and soothing from others (Mennin et al., 2007; Beesdo-Baum et al., 2012).

Additionally, the content of the rumination tends to be different in anxiety and depression (Yang et al., 2014). With anxiety, the function of rumination is usually to prepare for a possible threat (Llera and Newman, 2014). Thus, when confronted with an emotionally arousing event, anxious individuals likely do not experience the full emotional impact (Llera and Newman, 2014). Indeed, it has been argued that the ruminative worry in GAD may serve as a defensive avoidance against thinking about more difficult issues (Crits-Christoph et al., 1996). In contrast, rumination in depression

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tends to focus on past events with the individual attempting to gain insight into what went wrong (Yang et al., 2014). Often the understanding they come to is that it was their own badness that led the negative experiences to occur. This tends to be associated with feelings of self-blame and guilt (McWilliams, 1994). Thus, the idea that these factors represent both commonalities and differences between anxiety and depression highlights the complexity of these psychological constructs and the need to assess both with a comprehensive assessment.

Research demonstrates that utilizing a multi-method assessment approach (i.e., including both self-report and free response based tests etc.) is most helpful in distinguishing complex psychological constructs such as anxiety and depression (Mihura, 2012). Unfortunately, previous research examining transdiagnostic factors such as rumination has primarily utilized self-report measures (McEvoy et al., 2013; Yang et al., 2014). Although self-report measures are an important part of any assessment, individuals may not be fully aware of all aspects of their emotional distress (Reinecke et al., 2010; Wachtel, 2011). For example, anxiety can be repressed to the extent that the individual is unaware of its presence (Derakshan et al., 2007; Wachtel, 2011). Thus, a holistic assessment must include both self-report measures as well as measures capable of illuminating implicit anxious symptomology (Campos, 2011; Mihura, 2012; Quirin and Bode, 2014). Performance-based tasks are likely to be helpful in the latter as they are thought to measure implicit processes beyond what a patient can articulate through immediate self-reflection (Campos, 2011; Malone et al., 2013).

The Rorschach is the most commonly used performance-based measure (Campos, 2011) and several studies have examined the Rorschach's ability to measure constructs related to anxiety and depression. These studies have shown a number of important findings between various Rorschach variables and the following transdiagnostic factors in anxiety and depression: 1. Feelings of sadness (Schlesinger and Fox, 1980; Mihura et al., 2013); 2. Feelings of helplessness (McCown et al., 1992); 3. Self-soothing strategies (Marsh and Viglione, 1992); And, 4. Rumination and other types of cognitive agitation associated with stress (McCown et al., 1992; Exner, 1993). Thus, this study will follow up on this research by exploring these transdiagnostic features in relationship to GAD and dysthymia using the Rorschach.

Given that anxiety and depressive disorders frequently co-occur, "pure" cases of GAD and dysthymia are infrequent in the general population (Bruce et al., 2001; Sansone and Correll, 2005). In fact, previous research has suggested that the co-morbidity between GAD and dysthymia is as high as 50% (Brown et al., 2001; Antony and Stein, 2009). This high rate of comorbidity suggests that studies which rely on "pure" cases are likely to be less generalizable. Indeed, Westen (2005) suggests that comorbidity should be viewed as an essential part of the symptom picture as it can have important implications for the understanding, prognosis, and treatment of highly comorbid disorders. Thus, in addition to controlled trials, naturalistic studies examining the shared and distinct features of GAD and depression are needed. The current study hopes to initiate this more ecologically valid method of exploring the relationship between depression and GAD by utilizing a sample of GAD patients with comorbidity rates comparable to those found in the general population. This representative sample of GAD patients will be compared to a group of individuals with dysthymia who do not have a co-morbid anxiety disorder in an effort to better understand the transdiagnostic factors in anxiety and depression.

2. Method

2.1. Participants

The participants utilized in this study were patients seeking treatment at a university based community clinic operated as part of an American Psychological Association (APA) approved doctoral program in Clinical Psychology. Cases were then assigned to treatment practice in an ecologically valid manner based on real world issues regarding aspects of clinician availability, caseload, etc. The participants in this study (N=36) were those assigned to a Psychodynamic Psychotherapy Treatment Team and research program (PPTT) who had a diagnosis of GAD and/or dysthymia. Table 1 displays demographic and diagnostic information for these patients. Analyses of differences between the two groups on all of the demographic variables reported in Table 1 (i.e., gender, age, marital status) demonstrated non-significant *p* values, > 0.05. In accordance with the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.; DSM-IV; American Psychiatric Association, 1994), 21 of the patients met criteria for dysthymia and did not have a comorbid anxiety disorder. Fifteen patients met DSM-IV criteria for GAD. Of the GAD patients, 7 had a comorbid depression diagnosis (4 major depression and 3 dysthymia) whereas 8 did not have co-morbid depression. In addition, approximately 64% of the participants in this study had a comorbid personality disorder, with the majority being Cluster B followed by Cluster C. The distribution of participants diagnosed with personality disorders was approximately the same for the GAD and dysthymia group. (For more information refer to Table 1).

2.2. Clinicians

Advanced graduate students (9 men and 11 women) enrolled in an APA approved Clinical Psychology PH.D. program conducted the psychological assessment. All clinicians were in their 2nd or 3rd year of training and had completed graduate courses in descriptive psychopathology and assessment. They were supervised by a licensed, PH.D., clinical psychologist with several years of applied experience. Each trainee received a minimum of 3.5 h of supervision per week (1.5 h individually and 2 h in a group treatment team meeting). Ten of the trainees saw 1 patient, 7 saw 2 patients, 2 saw 3 patients, and 1 clinician saw 5 patients. In addition, the project supervisor saw 1 patient.

2.3. Procedure

All patients who sought treatment were assigned a clinician who conducted the assessment at the onset of therapy. Prior to the

Table 1
Participant demographic, Mean GAF ratings, and mean BSI anxiety scores.

| | GAD | Dysthymia | Total |
|---------------------------------------|----------|-----------|----------|
| | n=15 | n=21 | n=36 |
| Mean Age | 26.7 | 31.9 | 29.72 |
| Gender | | | |
| Male | 2 (13%) | 9 (43%) | 11 (31%) |
| Female | 13 (87%) | 12 (57%) | 25 (69%) |
| Marital Status | | | |
| Single | 12 (80%) | 16 (76%) | 28 (78%) |
| Married | 2 (13%) | 2(10%) | 4 (11%) |
| Divorced | 1 (7%) | 3(14%) | 4(11%) |
| Personality Disorder Diagnosis | 10 (67%) | 13 (62%) | 23 (64%) |
| Cluster A | 0 (0%) | 1 (5%) | 1 (3%) |
| Cluster B | 6 (40%) | 8 (38%) | 14 (39%) |
| Cluster C | 4 (27%) | 4 (19%) | 8 (22%) |
| Mean GAF (Eval) | 58.40 | 61.38 | 60.14 |
| BSI Anxiety (Eval) | 1.55 | 0.98 | 1.22 |

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