Specificity of Interpersonal Problems in Generalized Anxiety Disorder Versus Other Anxiety Disorders and Depression

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Abstract: We examined the diagnostic specificity of interpersonal problems (IP) in generalized anxiety disorder (GAD). We expected generally higher interpersonal distress, and specifically higher levels of nonassertive, exploitable, overly nurturant, and intrusive behavior in n = 58 patients with Diagnostic and Statistical Manual of Mental Disorders, 4th Edition GAD compared with patients with post-traumatic stress disorder (n = 46), other anxiety disorders (n = 47), and unipolar depressive disorders (n = 47). IP were assessed with the Inventory of Interpersonal Problems. Specificity in the sense of heightened interpersonal distress for GAD was not supported in any of the aforementioned scales, neither for pure nor for comorbid GAD. This finding persisted after accounting for the degree of depressivenessness (Beck Depression Inventory). GAD patients are rather not characterized by more self-ascribed IPs although they may worry more about interpersonal issues in general.

Key Words: Interpersonal problems, generalized anxiety disorder, post-traumatic stress disorder, unipolar depression, social avoidance.

Interpersonal problems (IP) have been suggested to specifically contribute to the development and maintenance of generalized anxiety disorder (GAD) (Newman et al., 2008). Several studies have identified interpersonal relationships as a typical domain of worry in Diagnostic and Statistical Manual of Mental Disorders, 3rd Edition, Revised (DSM-III-R) GAD (Becker et al., 2003; Roemer et al., 1997). Although they constitute a predominant content of worry in GAD, previous studies did not investigate whether patients really experience corresponding difficulties, that is, whether IPs were increased in GAD in comparison to other clinical groups. Therefore, the relative importance of IP in GAD is largely unknown to date.

The idea of IP being particularly important in GAD also arises from the clinical observation that the patients’ worries often concern issues with partners, children, or other relatives, e.g., that they may suffer an accident. Reassurance-seeking meant to reduce these worries may involve controlling behavior toward family members, which may in turn lead to enhanced IP (Wells, 2005). Accordingly, Whisman et al. (2000) found more marital discord in couples with a DSM-III-R GAD patient than in couples with a patient suffering from other axis I disorders. Furthermore, checking behaviors and reassurance-seeking toward others—both dysfunctional approaches to cope with anxiety—are suspected to deplete social resources and to undermine patient’s independence. In a study by Erickson and Newman (2007), students with high scores on a dimensional measure of GAD-related worry and anxiety (but not controls) tended to over- or underestimate their hostile-submissive effect on others (assessed with the Impact Message Inventory-IIA Octant Scale Version, Kiesler and Schmidt, 1993). This misestimation of impact was linked to less liking by interaction partners. Pointing at the practical relevance of IP in psychotherapy, Borkovec et al. (2002) found that pretherapy IP predicted negative outcome of cognitive-behavioral therapy (CBT) for GAD. Finally, Newman et al. (2008) found the integration of elements of interpersonal therapy into CBT interventions for GAD to be beneficial.

Using the Inventory of Interpersonal Problems (IIP; Horowitz et al., 2000a, see the Methods section for a description), Salzer et al. (2008) identified typical IP profiles among patients with DSM-IV GAD. More than 50% of patients predominantly experienced problems with exploitable behavior. The predominant problems of another 25% of patients were revealed in adjacent domains (nonassertive and intrusive). Similarly, Borkovec et al. (2004) cited unpublished research with the IIP in which the majority of GAD patients reported pronounced overly nurturant and intrusive behaviors. All these behaviors are located in and around the fourth quadrant of the interpersonal circumplex (friend-submissiveive, Horowitz et al., 2000a). Salzer et al. (2008) discuss that patients with GAD may sacrifice their own needs in favor of others’ needs and may, as a consequence, experience themselves as submissive. Borkovec et al. (2004) speculate that worry may be involved in these interpersonal processes and may serve as a method for anticipating the needs of significant others.

However, none of these previous studies has empirically tested whether IP are generally or specifically increased in DSM-IV-defined GAD compared with other clinical groups. As a result, the clinical specificity of IP in GAD remains to be shown. Therefore, the current study examines the profile of IP in patients with GAD compared with post-traumatic stress disorder (PTSD) and other anxiety disorders. As the nosologic relationship between GAD and major depression has been critically debated (Beesdo et al., 2010; Hettema, 2008), we also explore the clinical specificity of GAD versus depression. On the level of overall interpersonal distress, we hypothesize higher scores among patients with GAD as compared with all other clinical groups. Furthermore, we expect GAD patients to exhibit especially pronounced problems with nonassertive, exploitable, overly nurturant, and/or intrusive behavior (Borkovec et al., 2004; Salzer et al., 2008).

METHODS

Participants were recruited among patients seeking psychotherapeutic treatment at the outpatient clinic for psychotherapy at the Technische Universität Dresden. All patients were routinely diagnosed using the DIA-X (Wittchen and Pfister, 1997), the computerized version of the DSM-IV Munich-Composite International Diagnostic Interview, a modified version of the WHO-CIDI (World Health Organization, 1990). In the first session after the diagnostic interview, current DIA-X diagnoses were validated by experienced clinicians and primary diagnoses were assigned. N = 198 patients with a primary diagnosis of either GAD, PTSD, any other anxiety disorder, or unipolar depression (dysthymia or major depression) were included in the current study. Participants gave written in-
formed consent and were categorized into 4 mutually exclusive diagnostic groups (Table 1): GAD, PTSD (no GAD), other anxiety disorders (no GAD, no PTSD; n = 9, specific phobia; n = 11, social phobia; n = 21, panic disorder w or w/o agoraphobia; n = 6, agoraphobia w/o history of panic); and depression (no GAD, no PTSD; n = 43, major depression; n = 4, dysthymia). Exclusion criteria included diagnosis of psychotic disorder and substance abuse disorder.

When only noncomorbid patients with GAD were included in the GAD group, values differed only marginally (n = 29; age: M = 46.9, SD = 14.5; 79.3% female). Forty-three patients with GAD were also part of the sample analyzed by Salzer et al. (2008). Diagnostic groups did not differ in age (F(3, 194) = 1.73; p = 0.16), but with respect to gender (χ²(3) = 8.02; p = 0.046; highest in PTSD: 78.3% female; lowest among other anxiety disorders: 55.3%). Therefore, gender was included as an independent variable in all statistical analyses considering group differences.

## Inventory of Interpersonal Problems

The 8 subscales of the IIP (8 items each, 4-point scale) represent problematic interpersonal behavior: PA, (too) domineering; BC, vindictive; DE, cold, FG, socially avoidant; HI, nonassertive; JK, exploitable; LM, overly nurturant; NO, intrusive (Horowitz et al., 2000a).

According to the interpersonal circumplex model these 8 scales (or octants) are equally spaced around the interpersonal circle, an assumption empirically supported and allowing for the reduction into 2 basic dimensions: Control and Affiliation that divide the circumplex space into 4 quadrants: I, friendly dominant; II, hostile-dominant; III, hostile submissive; and IV, friendly submissive. That way, both dimensions together define the location in circumplex space and mark the predominant interpersonal domain. Control and Affiliation scores are computed from ipsatized scores, that is, scores for each scale are corrected for the individual’s mean over all 8 scales before they are used to compute dimensional scores (Horowitz et al., 2000a).

The item mean score of the IIP serves as indicator for the overall level of interpersonal distress. Brähler et al. (1999) were able to reproduce the octagonal structure of the original version and report sufficient data on external validity for the German IIP (Horowitz et al., 2000b). To compare our clinical groups to a nonclinical and representative normative sample, we used data (N = 1332) reported by Stangier et al. (2006).

## Beck Depression Inventory (BDI)

The BDI (Beck et al., 1961; German version: Hautzinger et al., 1995) is the most widely used clinical self-report scale to assess depressive symptoms. It consists of 21 items on a 4-point Likert response scale with higher scores representing higher degrees of depressiveness. Richter et al. (1994) discuss the psychometric properties of the BDI and include studies using the German version of the BDI in their review. There is no indication that there are substantial differences with regard to internal and external validity between the original version and its translation used here.

## Statistical Analyses

We conducted multivariate analyses of (co)variance with the 8 IIP subscales as dependent variables and the fixed factors Group and Gender (4 × 2 design) using SPSS 16.0. The multivariate analyses were followed by univariate analyses for the 8 subscale scores, the item mean score, and both dimensional scores. The dependent variables were normally distributed in all 8 cells (Kolmogorov-Smirnov Test, all p > 0.37). Homogeneity of error variances was violated for the IIP mean score and IIP scales Cold and Exploitable (Levene’s test, all p < 0.05). The statistical analyses conducted should provide valid results given these minor violations of assumptions. To test for all potential group differences, we conducted Tukey’s HSD post hoc tests. Comparisons with the normative sample were computed using R (R Development Core Team, 2009) and the package HH (Heiberger, 2009).

## RESULTS

In the multivariate analysis of variance with the 8 subscale scores, we found significant multivariate effects for Group (F(24, 555) = 3.32, p < 0.001) and Group × Gender (F(24, 555) = 1.74, p = 0.02). The multivariate effect of Gender was not significant (F(8, 183) = 1.77, p = 0.08). Univariate analyses (Table 2) revealed that there were significant group differences for the subscales Vindictive, Cold, Socially Avoidant, Nonassertive, and Overly Nurturant. All these differences were because of heightened scores in the PTSD group (Table 2). We did not find any significant group differences on the remaining subscales or on the 2 basic dimensions Control and Affiliation. However, we observed a statistical trend for a Group difference in the subscale Domineering (F(3, 190) = 2.64, p = 0.051) and in the Affiliation dimension (F(3, 190) = 2.35, p = 0.07). The first trend is due to lower scores within the GAD group as compared with the PTSD group, the latter is mainly due to differences between patients with PTSD and patients with depression (Table 2). For the item mean score of the IIP, indicating global interpersonal distress, a significant group difference was found (Table 2). Post hoc tests revealed that this result was due to patients with PTSD reporting higher levels of overall interpersonal distress than all other groups. Figure 1 shows the mean profiles for all groups; the groups’ mean

### Table 1. Sample Description

<table>
<thead>
<tr>
<th>Variables</th>
<th>PTSD n = 46</th>
<th>Anxiety n = 47</th>
<th>Depression n = 47</th>
<th>GAD n = 58</th>
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<tbody>
<tr>
<td>Age in yr M (SD)</td>
<td>41.1 (15.4)</td>
<td>38.8 (12.1)</td>
<td>41.3 (13.7)</td>
<td>44.8 (13.6)</td>
</tr>
<tr>
<td>Gender in % female</td>
<td>78.3</td>
<td>55.3</td>
<td>68.1</td>
<td>77.6</td>
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<tr>
<td>Diagnoses/comorbidity</td>
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<tr>
<td>GAD (%)</td>
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<tr>
<td>PTSD (%)</td>
<td>46 (100)</td>
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<td>D No  A no</td>
<td>D No  A no</td>
<td>D No  A no</td>
<td>D No  A yes</td>
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</table>

D no/yes indicates diagnosis of major depression or dysthymia; A no/yes, diagnosis of any anxiety disorder excluding PTSD and GAD; PTSD, post-traumatic stress disorder; GAD, generalized anxiety disorder; SD, standard deviation.
TABLE 2. Mean Scores and Standard Deviations and Results of Analyses of (Co)variance for Patients With GAD, PTSD, Other Anxiety Disorders, and Depression

<table>
<thead>
<tr>
<th>Measures</th>
<th>PTSD W/O GAD (n = 46)</th>
<th>Anxiet W/O GAD (n = 47)</th>
<th>Depression W/O GAD (n = 47)</th>
<th>GAD (Including Comorbidity) (n = 58) F(3, 190) p</th>
<th>BDI as Covariate F(3, 189) p</th>
<th>GAD Pure (Excluding Comorbidity) (n = 29) F(3, 161) p</th>
<th>BDI as Covariate F(3, 160) p</th>
<th>Normative Sample (n = 1332)</th>
</tr>
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<tbody>
<tr>
<td>IIP total item mean score</td>
<td>1.81 ± 0.54b</td>
<td>1.54 ± 0.51b</td>
<td>1.55 ± 0.36b</td>
<td>1.43 ± 0.50b</td>
<td>6.62 &lt;0.001 A, D, G &lt; P</td>
<td>2.82 0.04</td>
<td>1.36 ± 0.52 6.64 &lt;0.001 A, D, G &lt; P</td>
<td>2.98 0.03 1.28 ± 0.58</td>
</tr>
<tr>
<td>Domineering (PA)</td>
<td>9.20 ± 5.66</td>
<td>8.64 ± 4.76</td>
<td>8.95 ± 5.60</td>
<td>6.53 ± 5.14b</td>
<td>2.64 0.051 —</td>
<td>1.32 0.27</td>
<td>6.48 ± 4.76 2.00 0.12 —</td>
<td>0.98 0.40 8.80 ± 5.20</td>
</tr>
<tr>
<td>Vindictive (BC)</td>
<td>11.25 ± 5.07b</td>
<td>10.02 ± 4.76b</td>
<td>9.19 ± 4.15</td>
<td>8.20 ± 5.87</td>
<td>2.67 0.049 G &lt; P</td>
<td>1.71 0.17</td>
<td>7.28 ± 5.93 3.34 0.02 G &lt; P</td>
<td>2.08 0.11 8.64 ± 4.72</td>
</tr>
<tr>
<td>Cold (DE)</td>
<td>14.07 ± 7.73b</td>
<td>9.86 ± 5.25</td>
<td>10.06 ± 5.26</td>
<td>9.16 ± 5.67</td>
<td>7.38 &lt;0.001 A, D, G &lt; P</td>
<td>4.18 0.007</td>
<td>8.03 ± 5.63 7.69 &lt;0.001 A, D, G &lt; P</td>
<td>4.14 0.007 9.60 ± 5.44</td>
</tr>
<tr>
<td>Socially avoidant (FG)</td>
<td>17.09 ± 7.35b</td>
<td>13.99 ± 7.30b</td>
<td>12.18 ± 6.00b</td>
<td>11.73 ± 6.85b</td>
<td>5.58 0.001 D, G &lt; P</td>
<td>3.92 0.01</td>
<td>10.11 ± 6.73 6.20 &lt;0.001 D, G &lt; P</td>
<td>4.38 0.005 10.08 ± 5.76</td>
</tr>
<tr>
<td>Nonassertive (HI)</td>
<td>18.18 ± 7.67b</td>
<td>14.91 ± 6.50b</td>
<td>14.83 ± 6.13b</td>
<td>16.09 ± 6.32b</td>
<td>2.83 0.04 —</td>
<td>1.99 0.12</td>
<td>14.41 ± 6.42 2.92 0.04 —</td>
<td>1.41 0.24 11.52 ± 6.00</td>
</tr>
<tr>
<td>Exploitable (JK)</td>
<td>15.89 ± 6.44b</td>
<td>13.98 ± 5.46b</td>
<td>15.07 ± 4.07b</td>
<td>14.55 ± 4.93b</td>
<td>1.91 0.13 —</td>
<td>0.40 0.76</td>
<td>14.79 ± 5.23 1.44 0.23 —</td>
<td>0.43 0.73 11.60 ± 5.28</td>
</tr>
<tr>
<td>Overly nurturant (LM)</td>
<td>17.91 ± 6.06b</td>
<td>14.88 ± 4.59b</td>
<td>16.51 ± 4.06b</td>
<td>14.31 ± 4.87b</td>
<td>9.13 &lt;0.001 A, G &lt; P</td>
<td>4.44 0.005</td>
<td>13.86 ± 4.33 8.07 &lt;0.001 A, G &lt; P</td>
<td>4.07 0.008 12.24 ± 4.96</td>
</tr>
<tr>
<td>Intrusive (NO)</td>
<td>12.05 ± 5.69b</td>
<td>12.23 ± 5.59b</td>
<td>12.24 ± 5.72b</td>
<td>11.14 ± 5.59b</td>
<td>0.80 0.50 —</td>
<td>0.26 0.86</td>
<td>12.00 ± 5.08 0.37 0.78 —</td>
<td>0.16 0.93 9.84 ± 4.88</td>
</tr>
<tr>
<td>Control</td>
<td>-0.59 ± 0.64b</td>
<td>-0.39 ± 0.54b</td>
<td>-0.38 ± 0.57b</td>
<td>-0.54 ± 0.52b</td>
<td>0.77 0.51 —</td>
<td>0.67 0.57</td>
<td>-0.45 ± 0.48 0.65 0.58 —</td>
<td>0.34 0.80 0.16 ± 0.40</td>
</tr>
<tr>
<td>Affiliation</td>
<td>0.13 ± 0.60b</td>
<td>0.25 ± 0.40b</td>
<td>0.40 ± 0.45b</td>
<td>0.35 ± 0.49b</td>
<td>2.35 0.07 —</td>
<td>2.48 0.06</td>
<td>0.47 ± 0.46 2.71 0.047 P &lt;</td>
<td>2.46 0.064 0.15 ± 0.38</td>
</tr>
<tr>
<td>BDI</td>
<td>24.21 ± 9.91</td>
<td>15.47 ± 9.21</td>
<td>20.25 ± 8.82</td>
<td>14.27 ± 7.42</td>
<td>7.80 &lt;0.001 A, G &lt; P</td>
<td>12.07 ± 6.02</td>
<td>7.35 &lt;0.001 A, G &lt; P</td>
<td>12.07 ± 6.02 7.35 &lt;0.001 A, G &lt; P</td>
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</table>

*Post hoc: Tukey’s HSD.
Significantly different from German normative sample (ANOVA and post hoc Tukey’s HSD).
Unipsatized scores.
Ipsatized scores.
PTSD, post-traumatic stress disorder; GAD, generalized anxiety disorder; BDI, Beck depression inventory; G, generalized anxiety disorder; P, posttraumatic stress disorder; A, other anxiety disorders; D, depression; W/O, without.
location within the 2-dimensional circumplex model are apparent from Figure 2.

For the BDI score we found a highly significant Group difference \( F(3, 190) = 7.80, p < 0.001 \), but no significant effect for Gender \( F(1, 190) = 1.30, p = 0.25 \) or Group \( \times \) Gender \( F(3, 190) = 0.46, p = 0.71 \). To statistically control for different levels of depressiveness (Table 2), we added the BDI score as covariate into the model. The multivariate group effect remained significant \( F(24, 552) = 2.82, p < 0.001 \). In univariate analyses, the differences between groups for Vindictive and Nonassertive were not significant anymore (Table 2).

When repeating the analyses using noncomorbid patients with pure GAD \((n = 29)\) (Table 2), results were similar. The multivariate Group difference was highly significant \( F(24, 468) = 2.88, p < 0.001 \). The effects of Gender \( F(8, 154) = 1.33, p = 0.24 \) and Group \( \times \) Gender \( F(24, 468) = 1.42, p = 0.09 \) were not significant. Divergent results in univariate analyses did occur with respect to Affiliation: patients with GAD and Depression scored higher than those with PTSD (significant Group difference; \( F(3, 161) = 2.71, p = 0.047 \); Fig. 2).

Again, using the BDI score as covariate the Group effect remained significant \( F(24, 465) = 2.44; p < 0.001 \), whereas Gender \( F(8, 153) = 1.46, p = 0.18 \) and Group \( \times \) Gender \( F(24, 465) = 1.51, p = 0.06 \) were not. Univariate group differences were attenuated to nonsignificance for Vindictive, Nonassertive, and Affiliation (Table 2).

Finally, we compared our clinical groups with a normative population sample using analysis of covariance and Tukey’s HSD post hoc tests (superscripts in Table 2). Interestingly, patients with

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**FIGURE 1.** Unipated IIP profiles.

**FIGURE 2.** Location of group means within the circumplex model (based on ipsatized subscale scores).
pure GAD did not differ from the normative sample in the total item mean score and in the subscale Socially Avoidant, whereas all other clinical groups, including GAD with or without comorbidity, did differ. Furthermore, patients with GAD—indeed, independent of comorbidity—differed from the normative sample in the subscale Dominating, showing significantly lower values. Again, there was no indication of group differences between patients with GAD and the other clinical groups.

DISCUSSION

We compared IP in GAD to 3 other clinical groups (PTSD, other anxiety disorders, and depressive disorders) and found no indication of clinical diagnostic specificity in GAD. First and in contradiction to our first hypothesis, overall interpersonal distress among patients with GAD was not heightened—neither when compared with other clinical groups, nor when compared with a representative population sample. Instead, the results suggest that PTSD is characterized by higher levels of overall interpersonal distress when compared with other axis I disorders.

Our second hypothesis expecting a distinct profile of IP for GAD with pronounced problems due to nonassertive, exploitative, overly nurturant, and/or intrusive behavior was also not confirmed. GAD patients did not differ from other clinical groups in these domains—neither regarding raw scores nor regarding relative location within the circumplex model. All differences found were again due to the distinct role of PTSD. GAD, other anxiety disorders, and depression did not differ from each other in any of the domains of IP and it was PTSD, which stood out for enhanced IP.

Almost all group differences observed were due to domains of IP constituting the dimension Affiliation. PTSD patients showed less pronouncement on Affiliation and—unlike all other groups—did not differ from the normative sample with respect to this dimension. It is important to note that this does not contradict the finding that the absolute amount of interpersonal distress is higher in PTSD patients, since their heightened scores on both poles of Affiliation—for vindictive, cold, and socially avoidant behavior on the one side, and overly nurturant behavior on the other—balance out. The importance of social avoidance in PTSD corresponds to previous findings (Hofmann et al., 2003).

The clinical groups differed with respect to degree of depressiveness, a variable which has been shown to be related to IP (Stangier et al., 2006). When we partialled out the BDI score, all group differences on IP scales except one—for socially avoidant behavior—were attenuated to nonsignificance. As the use of analysis of covariance to partial out a third variable differing among (natural and nonrandomized) clinical groups of interest has been criticized (Miller and Chapman, 2001), it is important to note that concerning our hypotheses the pattern of results did not change depending on which form of analysis was applied. All analyses do not suggest that overall interpersonal distress was heightened in GAD or that a distinct IIP profile in GAD exists. Therefore, clinical specificity of IP could not be supported.

A closer look at the data reveals 2 statistical tendencies toward significance. The near-significant result regarding group differences for Affiliation are due to deviant scores of PTSD patients when compared with all other clinical groups, including GAD patients. Furthermore, there is a statistical tendency for GAD patients to conceive fewer problems with dominating interpersonal behaviors. Although this was not one of our a priori hypotheses, this (insignificant) pattern of results might be interpreted as mirroring our expectation that GAD patients might have problems with too submissive behaviors. Both subscales are, however, conceptually independent and empirically uncorrelated.

In summary, our data suggest that IP are pervasive throughout axis I disorders (with an attenuation in PTSD) and that they can be considered shared vulnerabilities, correlates, and/or consequences of psychopathology rather than GAD-specific features. This interpretation is further corroborated by our finding of higher overall interpersonal distress in all clinical groups compared with a normative sample. Remarkably, patients with GAD (especially pure GAD) constituted the group differing least from the normative sample.

Turning to the limitations of this study, it should be noted, however, that only GAD was examined in its pure form. Although we excluded patients currently meeting criteria for GAD from the non-GAD groups, there is still an overlap between these groups due to comorbidity other than GAD. As a consequence, the differences among the non-GAD groups may be underestimated. On the other hand, our sample is typical because all of these disorders usually occur with high rates of comorbidity.

As comorbidity is the rule rather than the exception within the current diagnostic system, a dimensional approach instead of the between-group design used in this study might be a promising avenue for the future (Kraemer, 2007; Shear et al., 2007). Dimensional independent variables would improve generalizability as no “pure” groups would be necessary. Dimensional constructs would also explicitly take account of overlap between diagnostic categories. A similar perspective is taken by Pincus and colleagues with their concept of pathoplasticity (Wright et al., 2009). Following their approach, the phenotype of, for example, IP depends on core symptoms of the disorder and on the extent of other functionally related variables such as, e.g., fear of failure. Dependent on whether the latter is high or low, different problematic interpersonal behaviors would occur within an individual. The concept of pathoplasticity accounts for the phenomenon of heterogeneous patterns of IP within a single diagnostic category and could deliver an alternative explanation for our findings.

A further alternative suggestion is to examine IP with methods that allow to test specific functional assumptions about interpersonal behaviors. The IIP, which we used in the current study, assesses general and more trail-like IP. Specific interpersonal behaviors that have been described to be typical for GAD, e.g., controlling behavior due to extreme concerns about loved ones that could potentially be hurt, or submissive behavior due to the need for reassurance, may explain the finding of the heightened marital discord in a GAD sample (Whisman et al., 2000), but might not be fully captured by a more global measure such as the IIP.

Finally, the operationalization of interpersonal issues as self-reported IP does not mirror the complete nature of interpersonal relationships, that is, the interaction partner’s perspective is not assessed. Therefore, the use of observational data, ecological momentary assessment (Schwartz and Stone, 1998), or other non-self-report measures (e.g., Impact Message Inventory, Kiesler and Schmidt, 2006) seems recommendable to gain a deeper understanding of the relationships between interpersonal issues (over and above IP) and psychopathology. More research that follows this direction of a more comprehensive operationalization of interpersonal issues and their various aspects is desirable.

What do we learn from our data for the theory and treatment of GAD? Our data show that GAD patients, although they may worry more about interpersonal issues (Becker et al., 2003; Roemer et al., 1997), are rather not characterized by more self-ascribed IP per se. We believe that the rationale to highlight IP in CBT of GAD (Newman et al., 2004) is not necessarily disconfirmed given these findings. It rather appears that IP are pervasive throughout the spectrum of anxiety and depressive disorders. Interpersonal therapy might therefore be a promising way to improve efficacy not only in the treatment of GAD, but also in a range of anxiety and mood
disorders. The empirical knowledge on which these interventions are grounded should, however, continuously be broadened. This applies especially to a more fine-grained clinical description of interpersonal behaviors and their potentially diagnosis-specific functions.

REFERENCES


