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CONVERGENCE OF DEPRESSION AND ANXIETY SYMPTOMS IN FRIENDSHIP DYADS

DANIEL F. GROS, MELISSA e. MILANAK, and RACHEL HERSHENBERG

Ralph H. Johnson VA Medical Center and Medical University of South Carolina

Abstract

Despite psychometric rationale to include multiple informants, psychological assessment typically involves data collected from the patient (target) only, particularly with regard to depressive and anxious symptomatology. This study addressed this gap in the literature by assessing convergence between targets and their close friends (informants) in an ethnically diverse sample of young adults. One hundred and thirty-nine friendship dyads completed a packet of questionnaires including different versions administered to the targets and informants, with targets completing the standard questionnaire battery focused on their own symptoms and informants completing questionnaires on their view of the target participants' symptoms, rather than their own characteristics. Measures were included to assess a wide range of symptomatology, including behavioral, cognitive, and physiological symptoms of anxiety and depression. The target-informant correlations were largely significant and of small-to-medium magnitude. In addition, target-informant agreement was higher in more visible symptoms (e.g., behavioral) than in less visible symptoms (e.g., physiological) of anxiety and depression. Interestingly, level of closeness in the relationship did not influence the magnitude of correlations. Implications for future research and integration into clinical assessment practices are discussed.

Evidence-Based Practice (EBP) involves the integration of research, clinical expertise, and patient values and preferences (Levant, 2005). Within an EBP framework, obtaining the best available research has implications for assessment as well as selection and implementation of treatments (Antony & Rowa, 2005; Hershenberg, Drabick, & Vivian, 2012). In terms of evidence-based assessments, many researchers suggest that the gold standard is the LEAD standard, standing for Longitudinal, Expert, and All Data (Kamphuis & Noordhof, 2009; Spitzer, 1983). The LEAD standard suggests that it is essential to collect data at multiple time points and from a variety of raters, which might include the self (target), close others (informants), and/or clinician. Indeed, multiple informants increase reliability because (1) random errors from both target and informant reports will cancel out, and (2) informant data will provide independent, incremental information if target reported data contains systematic sources of bias (Klonsky, Oltmanns, & Turkheimer, 2002). Research has demonstrated that targets may lack insight, being unable to accurately describe and/or identify maladaptive behaviors and patterns of thinking (Clifton, Turkheimer, & Oltmanns, 2005). In addition,

although targets may recognize impairment, they may be unwilling to disclose it for a variety of reasons (Leary & Kowalski, 1990). Lastly, rather than underreporting, some targets may exaggerate symptoms or engage in malingering behaviors in an attempt to gain attention or even monetary compensation/disability (Taylor, Frueh, & Asmundson, 2007).

Two of the most common presenting problems in clinical outpatient settings are symptoms of depression and anxiety (Kessler, Chiu, Demler, Merikangas, & Walters, 2005). Assessment practices for these symptoms vary tremendously. For example, with regard to depression, one review found evidence for a wide range of self-report and clinician-rated measures, citing as many as 90 self-report measures, 27 clinician-rating scales, and 6 diagnostic interviews (Basco, Krebaum, & Rush, 1997). Similar problems exist in the number of assessment tools for anxiety (Antony & Rowa, 2005). Although arguments have been made to standardize initial (and on-going) assessments (Barkham et al., 1998), the most common assessment procedures all fall prey to method variance as the bulk of the information is collected from the single source.

Thus, from an EBP perspective, the introduction of an additional informant into standard assessment procedures is highly recommended. However, there are some natural arguments against such an approach. In addition to concerns raised about patient confidentiality, additional informants exact a cost in the coordination, administration, and scoring of measures. Thus, in a climate in which bridging the gap between science and practice is of high importance (Teachman et al., 2012) and clinicians' rejection of impractical suggestions put forth from research is commonplace (Westen, Novotny, & Thompson-Brenner, 2004), it is important to investigate the potential value of informant reports, prior to arguing for their full implementation. Moving sequentially, before examining the incremental validity of such an addition, it is first important to investigate the magnitude of agreement with regard to these common symptom complaints.

The purpose of the present study was to compare scores between targets and informants on a range of common self-report measures designed to assess symptoms of and impairment from depression and anxiety. We investigated this question in a nonclinical sample to first establish typical rates of agreement on these symptom measures. The second purpose of the study was to examine which symptoms were most likely to converge or diverge between target and informant reports. The third purpose of the paper was to address if it "matters" who serves as the informant. In other words, thinking critically about the nature of the relationship with the informant, it is important to assess if the magnitude of agreement differs based on degree of closeness of the relationship.

Interestingly, there is very little previous research to guide hypotheses with regard to convergence of these symptoms. However, there are some notable exceptions. For example, Flett, Besser, & Hewitt (2005) found a correlation of .35 between young adult target and same-sex best friend informant reports of targets' depressive symptoms and their scores were not significantly different from one another. Additionally, using measures of depression and social anxiety, correlations between young adult target and friend or roommate informant reports of targets' symptoms were .37 and .39, respectively (Okazaki, 2002). Other studies have reported similar findings (Crowell et al., 2012; Gros, Simms, &

Antony, 2010). However, although each of these studies included a target-informant component, the research was not specifically focused on evaluating target-informant procedures for symptoms of depression and anxiety.

Importantly, though limited information is available regarding agreement on symptoms of depression and anxiety, vast research has been completed in the adult literature on personality and personality disorders (e.g., Klonsky et al., 2002; Simms, Zelazny, Yam, & Gros, 2010; Watson, Hubbard, & Wiese, 2000). Although a thorough review is beyond the scope of this manuscript, researchers have found a wide range of agreement between target and informant ratings (*rs* ranging from .25 to .62; Simms et al., 2010). Multiple factors influence the degree of association such as how visible (i.e., overt) the traits are, type/length of relationship with the informant rater, size of the sample, and age of the sample (Coolidge, Burns, & Mooney, 1995; Watson et al., 2000). Notably, some evidence suggests that the sample type (e.g., patient vs. nonpatient) generally does not affect correlations (Klonsky et al., 2002).

Based on the limited previous findings in the depression/anxiety literature (Flett et al., 2005; Okazaki, 2002) and more thorough findings from the personality literature (Watson et al., 2000), hypotheses were developed for each of the study aims. First, we expected medium-effect correlations between target-informant ratings for each of the scales. Second, we hypothesized that more visible symptoms (e.g., behavioral avoidance and substance use) would demonstrate higher agreement than less visible symptoms (e.g., physiological arousal and cognitive symptoms). Third, we hypothesized that closer/longer relationships would result in higher agreement. Given that the degree of association may differ based on the type of instrument used (Klonsky et al., 2002), we chose a wide variety of measures that assessed behavioral, cognitive, physiological, and emotional domains as well as a measure of functional impairment.

METHOD

PARTICIPANTS

One hundred and thirty-nine friendship dyads ($N = 278$; M age = 19.4, $SD = 2.2$; 52.2% male) from a large northeastern university participated in the study. The primary (target) participant signed up for the experiment on a recruitment website and was asked to bring a friend (informant) to the study session. The sample was diverse, made up of participants identifying as Caucasian (50.7%), Asian American (27.3%), African American (10.1%), Hispanic (5.0%), and other (6.8%). Participants earned research credit for approximately two hours of study time.

The 139 friendship dyads were roughly equal in sex break-down: male-male (36.0%), female-female (31.7%), and male-female (32.4%). Most target-informant dyads included participants from the same racial or ethnic background (76.3%). Friendship dyads included self-selected friends. The average friendship dyad reported that they had known each other for 19–24 months, spent at least 11–15 hours together each week, and knew each other very well on a 4-point scale (1 = Not well at all, 2 = A little, 3 = Moderately, 4 = Very well).

PROCEDURES

The procedures and measures used in this study were approved by an Institutional Review Board. Targets and informants attended the same study session and were placed at opposite ends of the room to prevent discussion. Once seated, the informed consent document was reviewed and signed. A questionnaire battery was administered via computer software that included the Depression Anxiety Stress Scales 21-Item Version (DASS; Lovibond & Lovibond, 1995), Intrusive Illness Ratings Scale (IIRS; Devins et al., 1984), Multidimensional Assessment of Social Anxiety (MASA; Gros, Simms, Antony, & McCabe, 2012), Positive Affect and Negative Affect Schedule (PANAS; Watson, Clark, & Tellegen, 1988), State Trait Inventory for Cognitive and Somatic Anxiety—Trait Scale (STICSA; Gros, Antony, Simms, & McCabe, 2007), Social Phobia Inventory (SPIN; Connor et al., 2000), and Personal Acquaintance Measure (PAM; Starzyk, Holden, Fabrigar, & MacDonald, 2006), as well as the demographic (e.g., age, sex, race) and relationship questions summarized above. Following questionnaire completion, participants were debriefed.

Targets and informants were administered their respective questionnaire batteries. Specifically, target participants completed the battery rating of their own functioning. Informants' instructions were modified so that their ratings were based on the symptoms of their friend (the target). Consistent with traditional methods for creating informant measures (Simms et al., 2010), the items in the informant questionnaire battery were changed from the first—(e.g., I am anxious) to the third-person (e.g., My friend is anxious).

MEASURES

Numerous measures were included in the present study to assess the behavioral, cognitive, physiological, and emotional symptoms and impairment of anxiety and depression. Each of these measures was selected based on their targeted symptoms as well as the support for their psychometric properties in the literature. The measures of behavioral symptoms included the MASA subscales for behavioral avoidance (MASA-BA), interoceptive avoidance (MASA-IA), and coping with substance (MASA-CS; Gros, McCabe, & Antony, in press; Gros et al., 2012; Gros, Simms, & Antony, 2011). The measures of cognitive symptoms included the MASA subscale of thought avoidance (MASA-TA) and the STICSA subscale for cognitive symptoms (STICSA-C; Gros et al., 2007; Ree, French, MacLeod, & Locke, 2008). The measures of physiological symptoms included the STICSA subscale for somatic symptoms (STICSA-S) and the SPIN subscale for physiological arousal (Antony, Coons, McCabe, Ashbaugh, & Swinson, 2006; Connor et al., 2000). The measures of emotional symptoms included the MASA subscale for anhedonia (MASA-ANH), the DASS subscales for depression (DASS-D), anxiety (DASS-A), and stress (DASS-S; Lovibond & Lovibond, 1995), and the PANAS subscales for positive affect (PANAS-PA) and negative affect (PANAS-NA; Roemer, 2001; Watson et al., 1988). The measures of impairment included the MASA subscale for impairment (MASA-FI) and IIRS total scale (Devins et al., 1984; Devins et al., 2001). And finally, the PAM was included to measure closeness in the relationship between the target and informant (Starzyk et al., 2006).

DATA ANALYSES

Prior to analyses, responses were inspected for significant missing data (greater than 10% of responses), resulting in the exclusion of five dyads. Next, to identify friendship dyads with unreliable ratings of their friendship on the PAM, difference scores were computed between the target and informant scale scores and two additional dyads were excluded due to outlying values. Thus, the final sample included 132 dyads (262 total participants).

The magnitudes of the association between target and informant ratings across domains of all measures were calculated by correlation coefficients. A series of paired-samples *t*-tests were used to investigate significant differences between the target and informant scores. To examine if the magnitude of the association differed between and within types of symptoms and impairment, *z*-tests were used to compare the magnitude of the correlations. In addition, to examine if the magnitude of the association differed based on degree of closeness in the relationship, we used a median split to divide dyads into high and low levels of friendship closeness and used independent samples *z*-tests to compare the magnitude of the correlations between the two groups across the various symptoms (behavioral, cognitive, physiological, emotional) and impairment.

RESULTS

TARGET-INFORMANT AGREEMENT

As shown in Table 1, there was a wide range of magnitude of agreement observed across the various measures (*rs* ranged from $-.02$ to $.35$). The differences in scale scores were significant for only five of the fifteen scales, including scales of the MASA (behavioral avoidance, coping with substance, thought avoidance) and STICSA (cognitive anxiety, somatic anxiety). Interestingly, target scores were higher in all cases when scores were significantly different.

TARGET-INFORMANT AGREEMENT WITHIN AND BETWEEN THE SYMPTOM DOMAINS

Differences were investigated within each cluster of symptoms (behavioral, cognitive, physiological, emotional) and impairment. The only significant difference was observed within the emotional scales, in which the target-informant agreement on the PANAS-NA scale (negative affect) was significantly smaller than MASA-ANH (anhedonia; $z = 2.1$; $p < .05$). Next, differences were investigated between the symptom clusters, with differences primarily demonstrated between the physiological scales with the other domains. Specifically, the SPIN-PA (physiological arousal) demonstrated significantly lower target-informant agreement than behavioral (MASA-BA, MASA-IA, MASA-CS), cognitive (STICSA-COG), emotional (DASS-S, DASS-D), and impairment (IIRS, MASA-FI) scales ($zs > 2.2$; $ps < .05$). Although a similar pattern of findings was found for the other physiological measure (STICSA-S), these differences were not significant ($zs < 1.9$; $ps > .07$). Additional symptom cluster differences were found between the PANAS-NA and MASA-CS and IIRS scales ($zs > 1.9$; $ps < .05$); however, these findings did not represent patterns across clusters, nor did they address any of the *a priori* hypotheses.

INFLUENCE OF CLOSENESS IN RELATIONSHIP ON TARGET-INFORMANT AGREEMENT

Although the correlations were larger in the close relationship (high PAM) group compared to the low PAM group on 11 of the 13 measures (r differences ranged from .02 to .46), only two of these differences emerged as significant. Specifically, these differences emerged on MASA-CS (coping with substances) and MASA-ANH (anhedonia) scales (z s > 2.0; p s < .05).

DISCUSSION

Despite the prevalence of examining convergence between target and informant reports of personality (Klonsky et al., 2002; Simms et al., 2010; Watson et al., 2000), there is a dearth in the literature examining convergence of symptoms of depression and anxiety. This is surprising given (1) large prevalence of depression and anxiety in clinical outpatient settings (Kessler et al., 2005) and (2) the emphasis of routine evidence-based assessments as part of EBP (Antony & Rowa, 2005; Hershenberg et al., 2012). Thus, the present study investigated target-informant agreement in young adult friendship dyads to provide initial findings to inform clinical assessment practices regarding informant reports. As expected, associations generally were medium-sized correlations and were roughly consistent with initial findings previously reported (Flett et al., 2005; Okazaki, 2002).

The target-informant findings were somewhat lower than in the personality literature, which typically range from .30 to .55 (Ready & Clark, 2005). Interestingly, when differences did emerge in the present findings, target reports were consistently higher in rating their own symptoms/impairment than were the informant reports. This pattern of findings is consistent with initial findings in depression and anxiety (Okazaki, 2002), but inconsistent in the personality literature (Klonsky et al., 2002). One possible explanation of this pattern may be that targets attempt to hide or conceal their symptoms of anxiety and depression from observers. In contrast to personality pathology where insight and control of symptoms may be poor (Sheets & Craighead, 2007), insight into the symptoms of anxiety and depression is often required for clinical diagnosis, allowing for efforts to hide them from others and/or avoid situations in which symptoms are likely to occur.

There also was evidence of patterned variability in target-informant agreement between symptom clusters. Specifically, the associations that tended to be reliably lower were characterized by lower visibility (physiological arousal). Consistent with this finding, easily observable personality traits with behavioral manifestations evidence higher self-other agreement than internal, subjective traits in the personality literature (Watson et al., 2000). Similarly, the more visible behavioral symptoms (avoidance and substance use) demonstrated higher target-informant agreement.

Lastly, we also examined the influence of the level of closeness in the relationship on the strength of the associations. Largely consistent with Okazaki (2002) who did not find that level of familiarity or relationship length was associated with degree of agreement, significant differences only emerged for two out of thirteen of the indices in the present study. Interestingly, the scales that demonstrated differences (e.g., coping with substance and anhedonia) also evidenced some of the largest target-informant agreement, and

potentially were the most visible symptoms as hypothesized above. Although additional replication is needed, these findings may suggest that closeness of relationship may only influence target-informant agreement when symptoms are highly visible (e.g., difficult to hide). On a related note, the personality literature has demonstrated that some alternative types of relationships (e.g., marriages with longer durations) result in higher target-informant agreement (Coolidge et al., 1995; Watson et al., 2000). As the present study was limited to dyads of close friends, future research should incorporate more variability in type of relationship, with the potential of detecting more significant differences related to closeness in the relationship.

Although these findings must be replicated and extended in clinical samples, findings thus far suggest the following tentative conclusions. First, on average targets will endorse slightly higher rates of symptoms than close friend informants. Second, rates of agreement will be higher with more visible symptoms. Thus, assessment measures for informants that assess qualities such as anxious avoidance, anhedonic isolation, and coping with substance may be more reliable than less visible symptoms such as physiological arousal, which may benefit more from actual physiological measures such as heart rate, blood pressure, and skin conductance (Turpin, 1991). Lastly, at this point more stringent criteria for selection of the informant is not necessary, as by and large the degree of association did not differ based on degree of closeness in the dyad. Together, these findings may suggest that informant reports could and should be considered as a useful tool in the assessment of any visible symptoms of depression and anxiety by any available informant (e.g., spouse, roommate, close friend, friend providing transportation to appointment). However, the alternative argument also could be made that informant reports provide little additional benefit in the assessment of depression and anxiety, based on the low-to-medium agreement observed in the present findings. Additional research is needed, particularly in clinical settings in diagnostics and treatment outcome, to extend these initial findings, to determine incremental validity and thus better inform future assessment practices.

These findings may also have implications within an interpersonal framework. Indeed, when an individual in a close relationship experiences symptoms of depression and/or anxiety, it has been shown to negatively impact the other individual (e.g., contagion effects; see Joiner & Katz, 1999) as well as the dyad (see Davila & Beck, 2002; Stroud, Feinstein, Bhatia, Hershenberg, & Davila, in press). Thus, it may be useful in future research to include ratings of the informant's own symptomatology and examine both actor and partner effects using Actor-Partner Interdependence Models (Cook & Kenny, 2005; Kenny, 1996) to examine systematic sources of variance in the prediction of target-informant agreement.

Several limitations exist in the present study. As noted above, the sample included friendship dyads of young adults, limiting its generalizability to other populations as well as limiting the types and duration of the relationships. In the personality literature, agreement has been shown to improve with age (Klonsky et al., 2002), suggesting samples of older adults also be considered in future research. Participants also were required to choose their informants, potentially introducing the letter of recommendation problem (Klonsky et al., 2002). Although it may provide some logistical concerns, future research may want to consider selecting informants from a list of options, rather than allowing targets to choose.

Finally, the sample size was smaller than some of the previous self-other studies on personality pathology, and interview data in addition to the self and informant reports was not included.

These limitations notwithstanding, this study fills an important dearth in the literature. Moving forward, replication in a clinical sample is essential to extend the typical degree of magnitude across these symptom and impairment clusters. Empirically determining what agreement looks like, on average, is an essential first step in examining the validity. Given the present findings and potential utility of informant reports (Kamphuis & Noordhof, 2009; Spitzer, 1983), informant reports should be evaluated for incorporation into standard clinical assessment practices in both research and purely clinical settings.

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TABLE 1
Self-Other Agreement in Behavioral, Cognitive, Physiological, and Emotional Symptoms and Impairment

Scale	<u>Target</u> <i>M (SD)</i>	<u>Informant</u> <i>M (SD)</i>	<i>t</i>	<i>d</i>	<i>r</i>
Behavioral Symptoms					
MASA-Behavioral Avoidance	22.8 (9.3)	19.3 (7.9)	3.8**	0.41	.26**
MASA-Interceptive Avoidance	5.9 (3.1)	5.5 (2.6)	1.3	0.14	.28**
MASA-Coping w/Substance	8.9 (4.9)	6.8 (3.5)	5.0**	0.49	.35**
Cognitive Symptoms					
MASA-Thought Avoidance	14.8 (6.2)	12.3 (4.8)	4.1**	0.45	.20*
STLCSA-Trait-Cognitive	17.2 (7.0)	15.1 (6.1)	3.1**	0.32	.27**
Physiological Symptoms					
STLCSA-Trait-Somatic	17.1 (6.6)	15.2 (6.0)	2.6**	0.30	.15
SPLN-Physiological Arousal	0.0 (0.2)	0.1 (0.4)	0.8	0.32	-.02
Emotional Symptoms					
MASA-Anhedonia	11.1 (5.0)	10.9 (4.8)	0.4	0.04	.32**
DASS-Depression	21.7 (9.2)	20.9 (9.0)	0.8	0.09	.25**
DASS-Anxiety	21.3 (9.2)	20.4 (8.8)	0.9	0.10	.17
DASS-Stress	23.4 (8.8)	22.1 (9.2)	1.5	0.14	.29**
PANAS-Positive Affect	33.6 (7.7)	34.4 (6.5)	1.0	0.11	.21*
PANAS-Negative Affect	20.0 (7.3)	19.6 (7.1)	0.5	0.06	.11
Impairment					
MASA-Impairment	7.7 (4.1)	7.1 (3.3)	1.5	0.16	.23**
IIRS	22.9 (13.5)	22.7 (12.6)	0.2	0.02	.30**

Note. Target ($N = 131$) and informant ($N = 131$) columns presented as mean (standard deviation). MASA = Multidimensional Assessment of Social Anxiety; STICSAs = State-Trait Inventory for Cognitive and Somatic Anxiety; SPIN = Social Phobia Inventory; DASS = Depression Anxiety and Stress Scales; IIRS = Illness Intrusiveness Rating Scale.

*
 $p < .05$;

**
 $p < .01$.