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Personality Organization in Anxiety Disorders: Comparison of Generalized Anxiety Disorder and Panic Disorder

Anksiyete Bozukluklarında Kişilik Örgütlenmesi: Yaygın Anksiyete Bozukluğu ve Panik Bozukluğu Karşılaştırılması

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ABSTRACT

The objective of this study was to explore the level of personality organization in patients diagnosed with generalized anxiety disorder (GAD) and panic disorder (PD). The study comprised 86 patients undergoing treatment for GAD (n=46) and PD (n=40). Various tools were utilized for data collection including a Sociodemographic Data Collection Form, Personality Organization Diagnostic Form (PODF), Beck Depression Inventory (BDI), and Beck Anxiety Inventory (BAI). A significant difference was observed between the GAD and PD groups regarding the PODF scores for mature defense, anxiety, and depression. However, no significant difference was observed in relation to the PODF identity total score and primitive defense scores. Furthermore, the quality of object relations and the overall level of personality organization according to the PODF did not display any significant differences between the groups. According to the BDI, comorbid depressive symptoms were detected in 67.4% (n=58) of the participants with GAD and PD. There was no significant difference in the PODF scores, quality of object relations, and the overall level of personality organization between the group with comorbid depressive symptoms and the group without it.These findings suggest that while the primary focus of therapeutic interventions should be on targeting the specific type of anxiety disorder, assessing the level of personality organization in patients with GAD and PD could add valuable insights to individual case understanding, selection of psychotherapy approaches, and the treatment process..
Keywords: Personality organization, identity, generalized anxiety disorder, panic disorder

ÖZ

Bu çalışmada yaygın anksiyete bozukluğu (YAB) ve panik bozukluk (PB) hastalarında kişilik örgütlenme düzeylerinin incelenmesi amaçlanmıştır. Çalışma YAB (n=46) ve PB (n=40) tanısıyla izlemi yapılan 86 hasta ile yürütülmüştür. Katılımcılara sosyodemografik veri toplama formu, Kişilik Örgütlenmesi Tanı Formu (KÖTF), Beck Depresyon Ölçeği (BDÖ) ve Beck Anksiyete Ölçeği (BAÖ) uygulanmıştır. YAB ve PB gruplarında KÖTF olgun savunma, anksiyete ve depresyon puanları arasında anlamlı bir farklılık bulunurken, KÖTF kimlik toplam puanı ve ilkel savunma puanları açısından anlamlı bir farklılık bulunmamıştır. Gruplar arasında KÖTF'e göre nesne ilişkilerinin niteliği ve genel kişilik örgütlenmesi düzeyi açısından da anlamlı bir farklılık bulunmamıştır. BDÖ'ye göre katılımcıların %67,4 (n=58)'ünde YAB ve PB'ye komorbid olarak depresif belirtiler saptanmıştır. Komorbid depresif belirtileri olan ve olmayan gruplar arasında KÖTF puanları, nesne ilişkilerinin niteliği ve genel kişilik örgütlenme düzeyi açısından anlamlı bir farklılık bulunmamıştır. Sonuçlar, tedavide primer olarak anksiyete bozukluğu türünün hedef alınması gerektiğine işaret ederken, diğer taraftan YAB ve PB'de kişilik örgütlenme düzeyinin incelenmesinin bireylerin vaka bazında anlaşılmasına, psikoterapi yaklaşımlarının seçilmesine ve tedavi sürecine katkı sağlayabileceğini düşündürmektedir.
Anahtar sözcükler: Kişilik örgütlenmesi, kimlik, yaygın anksiyete bozukluğu, panik bozukluk

Introduction

Personality is defined as the dynamic organization of an individual's unique and enduring patterns of emotions, thoughts, behaviors, motivations, and ways of relating to others (Caligor et al. 2007). In other words, it is a complex pattern of characteristics that manifests in every aspect of psychological functioning (Millon et al. 2004). Non-pathological personality encompasses patterns of personality traits that are not extreme, flexible,

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and adaptable across different situations (Caligor et al. 2007). Pathological personality, on the other hand, includes maladaptive personality traits that persist across various situations and times, manifest specific patterns of emotions, thoughts, and behavioral patterns, lead to negative reflections in self and interpersonal relationships, and cause significant clinical distress and impairment in psychosocial functioning (Caligor et al. 2007, Hengartner et al. 2018). In the literature, several criteria are proposed for personality pathology, including deviation from societal expectations, rigidity, excessiveness, and disturbances related to roles, while it is noted that these factors affect how individuals perceive themselves and others and influence their reactions (Wright 2011, Zeigler-Hill and Marcus 2016, Hengartner et al. 2018). Hengartner et al. (2018) suggest that personality disorders and personality pathology are different concepts, with personality disorders not encompassing subclinical personality problems, being closely related to the categorical diagnosis of mental disorders, and therefore, personality disorders could be a subset of personality pathology.

Personality Organization (PO), as defined by Kernberg, represents a dynamic structure formed by stable, mostly unconscious, and early life experiences' influence (Kernberg 1996, Caligor and Clarkin 2010). Kernberg proposed a comprehensive model that integrates categorical approaches like DSM (Diagnostic and Statistical Manual of Mental Disorders), ICD (International Classification of Diseases), and dimensional approaches like the Five-Factor Model of Personality. This model is based on object relations theory that encompasses a spectrum of normal and pathological personalities, categorizing them into three levels of PO: normal, neurotic, and borderline. At the healthiest end of the spectrum lies normal PO, followed by neurotic PO, which corresponds to DSM-5-based Cluster C personality disorders. Borderline PO, which includes more severe levels, is positioned in the pathological section of the spectrum and corresponds to DSM-based Cluster A and B personality disorders. At the most pathological end, we find psychotic PO (Kernberg and Caligor 2005, Hörz-Sagstetter et al. 2018).

Generalized Anxiety Disorder (GAD) and Panic Disorder (PD) are psychiatric diagnoses classified under the umbrella of anxiety disorders. Although both disorders manifest with anxiety and physical symptoms in response to real or perceived threats, epidemiological, genetic, familial, and twin studies support their distinction as separate diagnoses (Weissman 1990). GAD is characterized by increased worry and tension about daily life events, often involving thinking about the worst possible outcome regarding issues such as health, money, family, friends, and work (APA 2013). These worries are often accompanied by thoughts about avoidance and precautionary behaviors related to potential threats (APA 1994, 2013). In contrast to the chronic low-level anxiety seen in GAD, PD involves the sudden onset of intense fear attacks with accompanying physical symptoms, followed by persistent worry about their recurrence and consequences (APA 1994). Both GAD (Conroy et al. 2020) and PD (Oussi et al. 2023) patients commonly experience difficulties in emotional regulation related to negative emotional experiences. Górska (2021) has suggested that personality pathologies in anxiety disorders may have an impact on emotional relationships. Furthermore, considering that personality pathology is commonly situated at the neurotic level of organization in anxiety disorders and depression (without psychotic features) (Widiger and Oltmanns 2017), it is relevant to explore how personality structure, particularly PO, might be associated with anxiety disorders.

On the other hand, with the increasing prevalence of anxiety disorders worldwide, it was reported that there were 45.82 million new cases of anxiety disorders in 2019 alone (Global Burden of Disease) (Yang et al. 2021). The lifetime prevalence of PD is estimated to be 1.6-3.5% (de Jonge et al. 2016), and severe cases of PD can lead to home confinement (Chen and Tsai 2016). For GAD, the lifetime prevalence varies but is estimated to be approximately 1.5-3% to 5% (Ruscio et al. 2017). Both PD and GAD are closely associated with impaired functionality (McKnight et al. 2016, Kim et al. 2021). Many individuals with PD or GAD do not respond sufficiently to treatment and/or carry a risk of relapse after remission (Perna and Caldirola 2017). Therefore, it is considered crucial to investigate potential clinical variables believed to have an impact on these psychopathologies. Given that PO encompasses an individual's perception of themselves, their environment, and others, as well as the defense mechanisms used to cope with anxiety, it is suggested that examining PO levels could contribute to understanding how well an individual can cope with anxiety and shape the nature and severity of their symptoms. Investigating the differences in PO levels between individuals with chronic low-level anxiety seen in GAD and individuals with intense, episodic anxiety attacks seen in PD could help explain these variations, offering insight into the nature of psychopathology in GAD and PD and guiding functional assessments and intervention methods that take organizational levels into account. Based on existing empirical data suggesting differences in the formation, continuity, and severity of anxiety manifestations between GAD and PD, our hypothesis postulates that the level of personality organization may be relatively higher in patients with GAD compared to those with PD. In the present study, we aim to explore the phenomenological and structural dimensions of PO levels in GAD and PD groups within the framework of personality psychodynamics.

Method

Sample

The study's sample consisted of voluntary participants who received treatment for GAD or PD at the Liv Hospital Samsun Psychiatry Outpatient Clinic between January 2021 and June 2021. The diagnoses were confirmed according to DSM-5 criteria, and participants provided informed written consent to participate in the study.

Inclusion criteria for the study required participants to have a diagnosis of GAD or PD according to DSM-5 and provide written informed consent to participate. Exclusion criteria included being under 18 years of age, being over 65 years of age, having a severe general medical condition detectable through the interview, having schizophrenia or other psychotic disorders, and having mental retardation or cognitive impairments that hindered communication.

The sample size for the current study was determined through a power analysis. Pilarska and Suchańska's (2015) study, which examined groups with various psychiatric diagnoses and non-diagnosed control groups and compared the scores on the Personality Organization Diagnostic Form (PODF) for individuals with and without psychiatric diagnoses, was used as a reference. A confidence level of 95% was used in the power analysis. The effect size from the Independent Samples t-test conducted in the reference study, which examined the difference in primitive defense scores on the PODF between groups with different psychiatric diagnoses and control groups, was calculated (d = 0.889). With a total of 80 observations (n1=40, n2=40), approximately 96% test power was achieved. Accordingly, 50 patients with GAD and 50 patients with PD receiving treatment at the Liv Hospital Samsun Psychiatry Outpatient Clinic were invited to participate in the study. Fourteen patients were not included in the study due to reasons such as not providing informed consent to participate, having psychotic symptoms, or not completing the measurement instruments. The study was conducted with 46 GAD patients and 40 PD patients who met the inclusion criteria for the current study.

Procedure

Before starting the study, ethical approval was obtained from the Samsun University Samsun Education and Research Hospital Clinical Research Ethics Committee (Date: 07.07.2021, Protocol No: GOKA/2021/13/1). This cross-sectional study was conducted at a single center, the Liv Hospital Samsun Psychiatry Clinic. Initially, informed consent forms were shared, and it was stated that participation was voluntary. After obtaining voluntary consent from participants, their sociodemographic data were recorded, and then PODF assessments were conducted. PODF was administered by a competent psychiatric specialist for each patient following a diagnostic interview lasting approximately 90 minutes. BAI and BDI were completed by patients in a self-report format as per the psychometric properties of the scales.

Measures

In the scope of the study, participants were administered the Socio-Demographic Data Collection Form, Personality Organization Diagnosis Form, Beck Anxiety Scale, and Beck Depression Scale.

Socio-Demographic Data Collection Form

This form was prepared by the researcher and was administered during the initial application by the researcher. It records participants' socio-demographic information such as age, gender, education, and employment status for the purpose of examination.

The Personality Organization Diagnostic Form (PODF)

Developed by Diguer to measure Personality Organization (PO) according to Kernberg's model, PODF is a clinician-rated scale (Diguer et al. 2006). PODF has been shown to be a valid and reliable assessment tool in various studies involving participants with varying levels of psychological functioning, ranging from severely disturbed psychotic organization to higher-level neurotic PO and normal individuals. It also demonstrates a good level of interrater reliability (Diguer et al. 2006, Hébert et al. 2010). PODF consists of 21 items and assesses five different dimensions of PO: identity, primitive defense mechanisms, mature defense mechanisms, reality testing, and object relations. Each dimension contains a specific number of items. Identity dimension has 6 items, primitive and mature defense mechanisms have 5 items each, and reality testing has 4 items. The fifth dimension is related to object relations and consists of a single item covering five different levels: fear of disintegration and annihilation with psychotic object relations, fear of object with low-level borderline object

relations, object control and exploitation with low-level borderline object relations, fear of abandonment and loneliness with high-level borderline object relations, and fear of retaliation with neurotic object relations. Finally, the global PO diagnosis is determined based on scores in the fifth dimension and other dimensions. In brief, Psychotic Personality Organization (PPO) is selected in the presence of identity diffusion, predominantly primitive defenses, impaired reality testing, and psychotic object relations. Borderline Personality Organization (BPO) is selected in the presence of identity diffusion, predominantly primitive defenses, predominantly good reality testing, and one of the three subtypes of borderline object relations. Normal Personality Organization (NPO) is selected in the presence of intact identity, predominantly mature defense mechanisms, good reality testing, and oedipal object relations.

The adaptation of PODF to Turkish was conducted by Yılmaz et al. (2012). Following validity and reliability studies, which included differences in interview flow and instruments compared to The Personality Organization Diagnostic Form, it was reported that PODF can be used with the Turkish sample (Yılmaz et al. 2012).

Beck Depression Inventory (BDI)

Beck Depression Inventory is a 21-item self-report scale (Beck et al. 1961) used to assess the severity of depression. Individuals are asked to rate themselves on a Likert-type scale ranging from 0 to 3 (0: least, 3: most; score range: 0 to 63) for each item. Increasing scores indicate the severity and intensity of depressive symptoms. The Turkish version of the scale has been shown to be valid and reliable; internal consistency (Cronbach's Alpha) was reported as 0.89, and test-retest reliability was 0.81 (Hisli 1988).

Beck Anxiety Inventory (BAI)

Beck Anxiety Inventory is a 21-item self-report scale (Beck et al. 1988) used to measure the subjective and physiological symptoms of anxiety. Each item has a 4-point Likert rating (0: none, 3: severe; score range: 0 to 63). Increasing scores indicate the severity of anxiety. The Turkish version of the scale has been shown to be a valid and reliable measurement tool. The internal consistency (Cronbach's Alpha) of the Turkish version was found to be 0.93, and test-retest reliability was 0.83 (Ulusoy et al. 1998).

Statistical Analysis

Statistical analysis for this study were conducted using IBM SPSS 25.0 (Statistical Package for the Social Sciences). The normality of the data distribution was evaluated based on the measures of skewness, kurtosis, the Kolmogorov-Smirnov test, and histogram graphs. As the data did not predominantly meet the assumption of normal distribution, non-parametric statistical analysis were employed to examine clinical characteristics between groups, with effect sizes calculated for the relevant analysis. To determine whether there was a significant difference between the GAD and PD groups in terms of anxiety, depression scores, and the total scores of the Personality Organization Diagnostic Form (PODF) related to identity, primitive, and mature defense mechanisms, Mann-Whitney U test was applied. Additionally, Mann-Whitney U tests were conducted to compare the total scores of identity, primitive, and mature defense mechanisms on the PODF between participants with comorbid depressive features and those without comorbid depressive features within the PD or GAD anxiety disorders. Chi-square tests were employed to examine the relationships between qualitative (categorical) data, and effect sizes were calculated (φ=) (Fritz et al. 2012). The significance level for the statistical analyses was set at $p < 0.05$.

Results

When examining the sociodemographic characteristics of the GAD and PD groups, no statistically significant differences were found between the two groups in terms of age, gender, years of education, and marital status (Table 1). However, a statistically significant difference was observed between the two groups in terms of employment status, and the effect size of this difference was small (φ: 0.21) (Kim, 2017).

Comparison of anxiety and depression scores between the GAD and PD groups and the total scores on the PODF related to identity, primitive and mature defense mechanisms, reality testing, the quality of object relations, and global Personality Organization (PO) are presented in Table 2. The Mann-Whitney U test results revealed a significant difference between the GAD and PD groups in terms of anxiety levels, depression levels, and mature defense mechanism scores ($p < 0.05$), while there was no significant difference in the scores related to identity and primitive defense mechanisms ($p > 0.05$). The GAD group had higher anxiety and depression scores compared to the PD group, whereas mature defense mechanism scores were lower. When examining the effect

sizes of the differences between the groups, it was observed that the difference in anxiety (r = 0.42) and depression (r = 0.39) was of moderate magnitude, while the difference in mature defense mechanism scores (r = 0.29) was of low magnitude (Fritz et al. 2012). There was no deficiency in reality testing abilities for both groups, and there was no significant difference between the two groups in terms of the quality of object relations and global PO (p > 0.05).

Table 1. Comparison of groups in terms of sociodemographic data (n=86)

	GAD (n=46)		**PD (n=40)**				
	Mean ± SD				t (df)	p	
Age	30.0 ± 5.5		31.2 ± 5.3		1.395 (84)	0.228	
Education (year)	14.9 ± 3.0		15.1 ± 3.2		0.275 (84)	0.784	
	N	%	N	%	X^2 (df)	p	φ
Gender					1.543 (1)	0.167	
Male	18	39.1	21	52.5			
Female	28	60.9	19	47.5			
Marital Status					0.399 (1)	0.528	
Married	38	82.6	35	87.5			
Single	8	17.4	5	12.5			
Working status					3.983 (1)	0.046*	0.21
Employed	20	43.5	26	65			
Unemployed	26	56.5	14	35			

GAD: Generalized anxiety disorder; PD: Panic disorder; X^2: Chi-Square test; t: Independent Groups t-Test; φ: Chi-square effect size Phi value; *p<0.05

Table 2. Comparison of GAD and PD groups in terms of descriptive statistics and clinical characteristics

	GAD (n=46)	**PD (n =40)**	**GAD (n =46)**	**PD (n =40)**			
	Mean± SD		Mean rank		U	p	r
KÖTF Kimlik P.	4.2 ± 5.6	5.9 ± 2.6	41.5	45.8	826	0.412	
KÖTF İlkel Savunma Toplam P.	8.3 ± 2.7	7.9 ± 2.5	45.1	42.1	857	0.581	
KÖTF Olgun Savunma Toplam P.	5.5 ± 3.3	6.8 ± 3.1	35.6	50.3	606	0.006*	0.29
Beck Depresyon P.	25.6 ± 7.4	17.8 ± 9.1	53.2	32.3	503	0.000*	0.42
Beck Anksiyete P.	30.3 ± 12.3	18.6 ± 13.1	52.6	33.1	473	0.000*	0.39
N(%)	GAD		PD		X^2(df)	p	
Deficiency In Reality Testing							
None	46	100	40	100			
Quality of Object Relations							
2c	28	60.9	29	72.5	1.295 (1)	0.255	
3	18	39.1	11	27.5			
Global Personality Organization					1.295 (1)	0.255	
Borderline	28	60.9	29	72.5			
Neurotic	18	39.1	11	27.5			

GAD: Generalized Anxiety Disorder; PD: Panic Disorder; PODF: Personality Organization Diagnostic Form; 2c: High borderline personality organization; 3: Neurotic personality organization; X^2: Chi-Square test; U: Mann-Whitney U test; r: Mann-Whitney U test effect size; *p<0.05

Furthermore, upon considering the cutoff score of the Beck Depression Inventory (BDI), it was discerned that 67.4% (n=58) of all participants experienced moderate to severe depressive symptoms accompanying anxiety disorders. The GAD group had a higher prevalence rate of 76% (n=35) compared to 57.5% (n=23) in the PD group. The Mann-Whitney U test was employed to ascertain if the comorbid depressive symptoms significantly influenced the PODF scores. The results indicated no significant disparities in scores related to identity, and primitive and mature defense mechanisms between groups with and without comorbid depressive symptoms (p > 0.05). Similarly, no notable differences were observed in the quality of object relations and global PO when

comparing groups with and without concurrent depressive symptoms. These analytical outcomes are detailed in Table 3.

Table 3. Descriptive statistics and comparison of PODF scores of groups with and without depressive symptoms comorbid to anxiety disorder

	Without Comorbid Depressive Symptoms (n=28)	With Comorbid Depressive Symptoms (n=58)	Without Comorbid Depressive Symptoms (n=28)	With Comorbid Depressive Symptoms (n=58)	U	p
	$\bar{X}$± SD		Mean rank			
PODF Identity Score	4.7 ± 4.2	5.1 ± 4.7	41.6	44.4	758	0.616
PODF Primitive Defense Score	8.7 ± 2.4	7.8 ± 2.7	48.8	41	662.5	0.164
PODF Mature Defense Score.	5.1 ± 2.5	6.7 ±3.5	37.2	46.5	636	0.099
	n	%	n	%	X^2(df)	p
Deficiency In Reality Testing None	28	100	58	100		
Quality of Object Relations					2.807 (1)	0.94
2c	22	78.6	35	60.3		
3	6	21.4	23	39.7		
Global Personality Organization					2.807 (1)	0.94
Borderline	22	78.6	35	60.3		
Neurotic	6	21.4	23	39.7		

PODF: Personality Organization Diagnostic Form; 2c: High borderline personality organization; 3: Neurotic personality organization; X^2: Chi-Square test; U: Mann-Whitney U test; *p<0.05

Finally, the descriptive distribution of the types of object relations for the GAD and PD groups is shown in Table 4.

Table 4. Distribution of personality organization subtypes in the groups

	GAD (n=46)		PD (n=40)	
	N	%	N	%
Dependent	12	26.1	9	22.5
Narcissistic	14	30.4	19	47.5
Borderline	2	4.3	0	0
Depressive masochistic	2	4.3	2	5
Obsessive-compulsive	16	34.8	10	25
Paranoid, Schizoid, Schizotypal, Malignant narcissistic, Antisocial, Hysteric, Sado-masochistic, Histrionic	0	0	0	0

GAD: Generalized Anxiety Disorder; PD: Panic Disorder.

Discussion

The relationship between anxiety disorders and the concept of personality has been extensively explored in numerous scientific studies. In the literature, the relationship between anxiety disorders and the concept of personality has been recently approached as a general trend through dimensional approaches such as Cloninger's temperament and character model (TCI: Temperament and Character Inventory), the three-factor personality model (TPQ: Tridimensional Personality Questionnaire), or the five-factor personality model (NEO-PI: Neuroticism-Extraversion-Openness Inventory). However, it is also observed that the part of this mutual relationship that remains within the realm of personality is mostly discussed as "disorder" and therefore at the level of "illness," as found in the earlier and current versions of DSM and ICD (Kampman et al. 2014, 2017).

On the other hand, with the dimensional model proposed by DSM-5 and ICD-11 as an alternative to the categorical approach in personality disorders, the concept of Personality Organization (PO) has come back into focus, which also includes normal levels of personality (Fischer-Kern et al. 2011). Taking a psychodynamic perspective on personality and personality health contributes to understanding how anxiety disorders and related mechanisms are connected to the organization of personality structure (Fischer-Kern et al. 2011, Górska

2021). In this context, the current study is in line with the contemporary dimensional personality pathology (Alternative Model of Personality Disorder in DSM-5; Criteria A for Alternative DSM-5 Model for Personality Disorders) model and makes reference to a structural and dimensional psychodynamic approach. It compares the levels of Personality Organization (PO) in GAD and PD anxiety disorders, which are prevalent and associated with impairments in psychosocial functioning. The aim was to functionally understand the relationship between these disorders and the concept of personality.

In our study, no significant difference was found between the GAD and PD groups in terms of primitive defense and total scores on the Personality Organization Diagnostic Form (PODF). However, the PD group had higher scores in mature defense mechanisms compared to the GAD group, but this difference was found to be of low magnitude. On the other hand, there was no significant difference between the two groups in terms of global PO and the quality of object relations. Although there is no direct evidence of a relationship between anxiety disorders and the level of Personality Organization (PO), it is a widely accepted notion that anxiety disorders are more common in individuals with higher levels of PO (Cierpiałkowska and Jańczak 2013). In fact, in our study, it was found that both GAD and PD group patients had high levels of borderline (2c) and neurotic (3) organization. Some studies have suggested that personality pathologies are more common in GAD patients compared to other anxiety disorders (Reich et al. 1994, Dyck et al. 2001, Górska 2021), but these studies seem to take a perspective that focuses on personality pathology. Eckhardt-Henn et al. (2009) reported that the level of PO in anxiety disorders is lowest (lower level) in GAD, highest (upper level) in specific phobias, and that PD and agoraphobia fall between these two levels.

Gorska (2021), on the other hand, found both upper and lower-level PO in GAD patients and suggested that lower-level PO is associated with difficulties in emotion regulation and symptom severity, and that PO plays a partial mediating role in the relationship between processing emotions and symptom severity. While the findings seem to be in line with the reference to the difference in mature defense scores between the groups in our study, the effect of this difference was found to be quite low. However, in light of Gorska's (2021) findings, the low effect of the difference may be related to the presence of both lower-level and upper-level PO in GAD. Indeed, our study showed that GAD patients had upper-level organization, and the difference in mature defense scores did not reflect a difference in organization level. It is possible that the differentiation of PO in GAD compared to other anxiety groups may vary depending on whether lower-level or upper-level organization is present. Pilarska and Suchańska (2015) found that the levels of primitive defenses, identity diffusion, superego pathology (moral values), reality testing, and aggression (aggressive attitudes and behaviors) included in PO were higher in clinical samples with various anxiety disorders and different psychopathology than the control group. However, it should be noted that the study included individuals with various clinical characteristics, including somatoform disorders, dissociative disorders, bipolar disorder, personality disorders, delusional disorders, and schizoaffective disorders. Therefore, it is thought that the source of the difference may be the heterogeneity of the clinical population. Doering et al. (2018) also found no significant differences in terms of personality functioning scores between GAD, PD, and phobic anxiety disorders and suggested that there was no significant relationship between PO and anxiety disorders. In the present study, Personality Organization (PO) was evaluated within a spectrum that also includes normal personality, and the personality structures observed in GAD and PD patients were determined in a clinical sample. Based on descriptive statistics in our results, in decreasing order of frequency, GAD was accompanied by obsessional-compulsive, narcissistic, dependent, borderline, and depressive-masochistic personality types, while PD was accompanied by narcissistic, obsessional-compulsive, dependent, and depressive-masochistic personality types.

A review of the literature reveals that there have been no studies investigating the relationship between GAD and PD and the type of object relations, which is one of the lower-level parameters of Personality Organization (PO). It is also noteworthy that in the literature, GAD and PD are generally compared in terms of the number and type of accompanying personality disorders within the framework of the concept of personality. Although studies suggesting that personality disorders are more common in GAD patients are predominant (Blashfield et al. 1994, Garyfallos et al. 1999, Dyck et al. 2001), one study stated that PD has more diverse personality disorders compared to GAD (Mauri et al. 1992). A meta-analysis study conducted by Friborg et al. (2013) mentioned that Cluster C personality disorders are common in GAD and PD. Another meta-analysis study by Ng and Bornstein (2005) reported that dependent personality disorder is more common in PD compared to GAD, and there is no significant relationship between GAD and dependent personality disorder. In Dyck et al.'s study (2001), the probability of having one or more personality disorders in GAD was found to be higher than in PD. Another study found no significant difference in terms of personality disorders between GAD and PD, and stated that avoidant personality features are a common feature represented in PD, GAD, and depressive disorders (Mauri et al. 1992). In other studies, PD was predominantly associated with dependent, avoidant, and obsessive-

compulsive personality disorders (Sciuto et al. 1991, Albert et al. 2006, Marchesi et al. 2006, Osma et al. 2014). As seen, there is no consensus in the literature regarding the type of personality accompanying GAD and PD, and it is noteworthy that all mentioned studies approach personality as a "disorder" and use a categorical approach. In the present study, personality was evaluated within a spectrum that includes normalcy, and the personality structures observed in GAD and PD patients in a clinical sample were identified. Our results, based on descriptive statistics, suggest that GAD is more frequently accompanied by personality types such as obsessional-compulsive, narcissistic, dependent, borderline, and depressive-masochistic, while PD is more frequently accompanied by narcissistic, obsessional-compulsive, dependent, and depressive-masochistic personality types.

In the present investigation, our analysis revealed elevated levels of anxiety and depression scores within the generalized anxiety disorder (GAD) group as compared to the panic disorder (PD) group. This is an unsurprising finding given the presence of more chronic anxiety (Salters-Pedneault et al. 2006) and high rates of comorbidity with depression in GAD (Saha et al. 2021). Furthermore, in our study, comorbid depressive symptoms were found in over 50% of both PD and GAD groups. Indeed, in the literature, it is mentioned that the comorbidity rate between these disorders is over 50%, and in lifetime diagnoses, this rate increases to 75-76% (Brown and Barlow 2009, Lamers et al. 2011). Barlow et al. (1986) have also stated that comorbidity in mental disorders is more of a rule than an exception. Moreover, due to avoidance behaviors in anxiety disorders, behavioral limitations and isolation tend to increase over time, negatively affecting the individual's social functioning and social support networks (Hickey et al. 2005, Friborg et al. 2013, Hendriks et al. 2014). The decrease in behavioral repertoire, social functionality, and support, along with the increase in limitations, is closely related to depressive features (Ferster 1973, Kupferberg et al. 2016, Alsubaie et al. 2019). Therefore, the presence of depressive features in the long term in an anxiety disorder clinic is considered clinically understandable.

In our study, there was no significant difference in terms of levels of Personality Organization (PO) between groups with and without comorbid depressive symptoms, which is in line with findings in the literature. In a study evaluating personality functioning according to the Alternative Model of Personality Disorders in DSM-5, which includes anxiety and mood disorders, personality dysfunction was found to be higher in clinical groups compared to control groups, with the highest dysfunction observed in the personality disorder group, followed by the anxiety and mood disorders group (Doubková et al. 2022).

Furthermore, close relationship coefficients have been reported between total Personality Organization Diagnostic Form (PODF) scores and anxiety disorder (0.55) and depression (0.54) scores (Sibilla et al. 2022). On the other hand, it is widely known that anxiety disorders and depression (without psychotic features) fall within the neurotic level of personality organization (Widiger and Oltmanns 2017). Additionally, avoidance of harm is considered a common structure in anxiety disorders and depression (Fassino et al. 2013), and the increase in avoidance is also associated with depression (Kampman and Poutanen, 2011, Komasi et al. 2022). Therefore, it is understandable that there is no difference in terms of PO between groups with and without comorbid depressive symptoms.

The current study has limitations in explaining causality due to its cross-sectional nature. Another limitation is the lack of a healthy control group for comparison with clinical and non-clinical sample groups. Considering the findings in the literature that point to differences in organizational levels for GAD, including both lower and upper levels of organization, including GAD groups with different organizational levels and a control group in future studies would contribute to clarifying the relationship between anxiety disorders and personality structure on a larger sample.

Conclusion

The levels of Personality Organization (PO) in GAD and PD patients were not found to be different, with both groups clustering around neurotic PO and high-level borderline PO. It is considered important to take this into account when selecting the psychotherapy method and therapeutic interventions in the psychotherapy process. On the other hand, the high depression-anxiety scores observed in the GAD group and the lower use of mature defense mechanisms in the GAD group compared to PD can provide guidance in developing treatment schemes for GAD. Possible differences in lower and upper-level PO in GAD may have an impact on clinical presentation and the healing process. Additionally, the lack of significant differences in terms of PO levels between groups suggests that in treatment, the primary focus should be on the type of anxiety disorder, while investigations related to PO can enhance functionality in the assessment and treatment process.

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