Generalized anxiety disorder: epidemiological data

Although generalized, persistent, free-floating anxiety had been described by Freud in 1894, the diagnostic term Generalized Anxiety Disorder (GAD) first appeared in 1980 in the DSM-III classification. In DSM-II GAD and panic disorder were classified under the term anxiety neurosis. In the subsequent diagnostic classification, i.e. DSM-III-R, DSM-IV as well as in ICD-10 the term GAD was retained but its diagnostic criteria were substantially changed each time. The result of the above frequent revisions was the absence of long-term comparable epidemiological data.

The prevalence of GAD, for instance, is markedly depending on the diagnostic classification that each study uses. In general, studies using DSM-III criteria report higher prevalence than those using DSM-III-R criteria which in turn find higher prevalence compared to studies using DSM-IV criteria. Furthermore, the use of ICD10 leads to a detection of higher GAD prevalence in comparison both to DSM-III-R and DSM-IV use. DSM-IV criteria are " stricter" as they include two criteria which are absent in the other classifications, i.e. the person finds it difficult to control the worry and the symptoms cause clinically significant distress or impairment while in addition the symptoms of the autonomous nervous system have been deleted.

The lifetime prevalence rate of GAD in the general population varies from 2.3% to 10.5%, the 12-month prevalence from 1.1% to 5.0%, while the current prevalence from 0.8% to 4.5%. Compared to other anxiety disorders, in the community, GAD is more frequent than panic disorder and obsessive-compulsive disorder while regarding agoraphobia and social phobia there are contradictory findings. Studies using DSMIII criteria report that GAD is more frequent than the two previously mentioned disorders while studies using DSM-III-R criteria report opposite findings.

GAD is the most frequent anxiety disorder in primary care settings with a current prevalence ranging from 2.9% to 22.6%. This wide range of the reported prevalence is due to the different diagnostic criteria used by different studies (studies using ICD-10 criteria find higher rates) but in addition to cultural factors as well as to the way the primary care services are organized in different countries.

Both in the community and in primary care there is a substantial number of patients with sub-threshold GAD. The annual prevalence of the sub-threshold GAD) in the community is 2.1% while; the rate increases to 7.8% if the criterion of duration is reduced from 6 months to 1 month. Similarly in primary care the current prevalence of sub-threshold GAD is as high as 4.1%. The above findings are very important, as subthreshold GAD is associated with significant social disability which is greater than that caused by chronic somatic diseases. GAD is usually an unrecognized disorder by primary care physicians. Its recognition rate (< 50%) is lower than that of panic disorder (62%). Reasons for not recognizing GAD include: patients' attitude to emphasize somatic symptoms such as insomnia, muscle tension, headaches, irritable bowel symptoms. The high comorbidity of GAD with somatic diseases, for instance GAD comorbidity with hypertension, is twice as high as expected by chance, misleads the physician who is focusing on the somatic disease exclusively. Finally another reason for this is the inadequate skills of primary care doctors, which is a result of their poor psychiatric education.

In contrast to primary care settings, GAD represents the least common anxiety disorder in mental health care settings.

The studies in the general population have shown that in GAD the sex ratio is approximately two-thirds female and in addition that the disorder is more prevalent in unemployed and in those who are divorced/separated or widowed. More than half of those presenting for treatment report onset in adolescence or even in childhood. However. onset in adulthood is not uncommon. It has been suggested that during childhood, patients with early onset of GAD, were exposed to more domestic disturbances, experienced more childhood fears and were more inhibited and socially maladjusted. On the contrary, lateonset has been associated with precipitating stressful life events. The occurrence of a negative life event triplicates the chance of GAD manifestation during the next year.
The course of the disorder is chronic but fluctuating and often worsens during times of stress. The highest prevalence, as lifetime diagnosis, appears at the age > 45 years, while the highest current prevalence between 25-34 years.

GAD usually comorbid with other clinical syndromes and its rate of comorbidity is the highest among the anxiety disorders. This is a finding from studies in the community but also from studies in primary care as well as from studies in mental health settings. The comorbidity rates range from 65-78% as current comorbid and up to 98% as lifetime one. It seems that women with GAD have higher comorbidity with other clinical syndromes than men while the most common comorbid diagnosis is major depression. The onset of GAD usually precedes the onset of the majority of the comorbid disorders except that of social phobia and specific phobias. The chance of GAD patient to develop a comorbid disorder increases dramatically with time. For instance, 39% of patients with GAD who had a comorbid diagnosis of major depression at intake, increased to 65% at 4 years and to 74% at 8-year follow up. GAD comorbidity has important clinical implications as it is related to more severe symptoms and overall psychopathology, occupational and social maladjustment, more problems in interpersonal relationships, worse prognosis and less favorable therapeutic outcome.

In conclusion, GAD is a frequent anxiety disorder in the general population, the most frequent anxiety disorder in primary care settings and not so frequent in mental health settings. Its prevalence is not exactly known as it is depending on the diagnostic criteria used and given that these criteria frequently change, it is not possible to have comparable long-term data. GAD is manifested approximately twice as often in women in comparison to men. The age at onset is usually early in life, the course is chronic but fluctuating and the highest current prevalence is between 24-34 years. GAD has high comorbidity with other clinical syndromes, especially in women, mainly major depression. Finally, GAD has a negative impact upon the overall patient's functioning especially in the cases of comorbidity.

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REFERENCES