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Generalized anxiety disorder: What are we missing?

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Abstract One of the most prevalent anxiety conditions seen in primary care is generalized anxiety disorder (GAD). Numerous physical ailments frequently accompany the psychic symptoms of anxiety, which often drive patients to ask for help. In spite of the high incidence of GAD, only 30% of sufferers are diagnosed. Furthermore, very few patients are prescribed medication or referred to a psychiatrist. The key aim is to ensure the early detection and management of these patients. Developing physician education programs may improve the identification of GAD. The use of simple diagnostic tools would also aid the early detection of sufferers. Physicians require more long-term data, including that on the influence of ethnicity and genetics, to assist them to better understand and more effectively manage GAD. By achieving early diagnosis and treatment of GAD, physicians can ensure that a lesser burden is inflicted upon sufferers, thus improving their quality of life.

1. Introduction

Anxiety disorders are considered to be the most prevalent of psychiatric disorders, with generalized anxiety disorder (GAD) believed to be one of the most common in the primary care setting (Wittchen et al., 2002). Indeed, GAD is present in nearly one-quarter of patients complaining of an anxiety condition to their primary care physician (PCP) (Wittchen et al., 2002). Regardless of this, many challenges in recognizing and treating GAD patients remain, most especially in primary care. In fact patients suffering with this anxiety disorder are as likely to initially seek out their PCP, than a psychiatrist, for the treatment of numerous associated somatic ailments, such as joint pain, weariness, or weight loss (Shear and Schulberg, 1995). Patients with an anxiety disorder are also more likely than other patient groups to make frequent medical appointments, undergo extensive medical investigations (Katon et al., 1992), present with medical and psychiatric comorbidities (Bowen et al., 2000; Noyes, 2001; Harter et al., 2003), report poor health, smoke cigarettes, and abuse other substances (Shader and Greenblatt, 1993). Physicians are also missing much of the clinical study data required to make a valid diagnosis of GAD, although a similar situation exists for many of the other mood and anxiety disorders. The name of the disorder may also be misleading—the focus of the condition is the cognitive dysfunction, which Karl Rickels eloquently refers to as an "intolerance of uncertainty." Perhaps an alternative name would more appropriately emphasize the specific symptoms associated with the disorder. All of these factors, to different degrees, compound the difficulty of the physician's task—that of assuring an accurate diagnosis (Stein, 2001).

GAD was first classified as a distinct disorder relatively recently, in 1980 (American Psychiatric Association, 1980). Previously little distinction was made between GAD and panic disorder (PD)—they were conceptualized as the core components of anxiety neurosis. The realization that GAD and PD are sufficiently different to be considered independently led to their separation in the *Diagnostic and*

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Statistical Manual of Mental Disorders, 4th edition (DSM-IV) (American Psychiatric Association, 1994). Having evolved from a residual syndrome with several nonspecific features into a more precisely defined condition, GAD is characterized by continual worry and tension about daily life events that are pervasive and uncontrollable, rather than by specific fears. GAD is notable by the duration (≥6 months), incidence, and the intensity of apprehension concerning an event being far out of proportion to the actual probability or impact of the experience (Sanderson and Barlow, 1990; Allgulander, 2001; Kessler et al., 2001a). The impairment should also be judged as not attributable to medication, another illness, or substance abuse. Further details of the DSM-IV criteria for the diagnosis of GAD are detailed in Table 1. The condition is accompanied by psychic symptoms such as restlessness, poor concentration, or irritability, and somatic symptoms including fatigue, muscle tension, and sleep difficulties (Allgulander et al., 2003). Indeed, in the PCP's office, this constellation of symptoms can look like the symptoms of numerous other medical conditions. Unfortunately, with only limited time to examine for additional symptoms and minimal acquaintance with psychiatric diagnoses, the PCP will often treat the presenting symptom, but miss the comprehensive diagnosis.

Table 1 Generalized anxiety disorder DSM-IV diagnostic criteria

- For more than half the days in at least 6 months, the patient experiences excessive anxiety and worry about several events or activities
- The patient has trouble controlling these feelings
- Associated with this anxiety and worry, the patient has three or more of the following symptoms, some of which are present for over half the days in the past 6 months: [a]
  - Feels restless, edgy, keyed up
  - Tires easily
  - Trouble concentrating
  - Irritability
  - Muscle tension
  - Sleep disturbance (difficulty falling or staying asleep, or restless, unsatisfying sleep)
- Aspects of another Axis I disorder do not provide the focus of the anxiety and worry[b]
- The symptoms cause clinically important distress or impair work, social or personal functioning
- The disorder is not directly caused by a general medical condition or by substance use, including medications and drugs of abuse
- It does not occur only during a Mood Disorder, Psychotic Disorder, or Pervasive Developmental Disorder

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[a] Children need fulfill only one of these six symptoms.

[b] Aspects of another Axis I disorder include worry about having a panic attack (e.g., panic disorder); public embarrassment (e.g., social phobia); being contaminated (e.g., obsessive-compulsive disorder); separation from home or relatives (e.g., separation anxiety disorder); weight gain (e.g., anorexia nervosa); having multiple physical symptoms (e.g., somatization disorder) or having a serious illness (e.g., hypochondriasis), and the anxiety and worry do not occur exclusively during post-traumatic stress disorder.

2. Diagnosis

In Europe, diagnosis is currently based upon the World Health Organization's (WHO's) *Tenth International Classification of Diseases* (ICD-10) (World Health Organization, 1992), while the DSM-IV classification is used in the USA generally and in Europe for research purposes. The DSM-IV emphasizes the psychic component (e.g., worry) rather than the somatic (e.g., muscle tension) or autonomic symptoms (e.g., diaphoresis or increased arousal) (American Psychiatric Association, 1994).

On initial inspection, the classification of anxiety disorders by the DSM-IV and the ICD-10 appear quite similar. However, recent discussions on GAD have suggested that the two systems may in fact recognize disparate groups of patients (Slade and Andrews, 2001). Differences exist and are evident in four aspects of the diagnostic criteria: typology, identifying criteria, and the inclusion and exclusion criteria. Further to this, data from the Australian National Mental Health Survey were used to model the impact of these differences on the diagnosis of GAD. The results showed that the concordance between the current classifications would be improved with the deletion of several measures from the DSM-IV, including the "uncontrollability" and "clinical significance" criteria (Andrews and Slade, 2002). Differences between the DSM-IV and the ICD-10 include the requirement under DSM-IV that the worry be excessive and cause clinically important distress or impairment, and the requirement in ICD-10 that GAD does not co-occur with panic/agoraphobia (PDA), social phobia (SP), or obsessive–compulsive disorder (OCD). Patients with GAD identified under DSM-IV show significantly higher levels of disability than those diagnosed under ICD-10, after controlling for demographic variables and the presence of comorbid psychiatric disorders (Slade and Andrews, 2001).

The ICD-10 and the DSM-IV diagnostic criteria are still subject to some debate (Maier et al., 2000; Kessler and Wittchen, 2002). Lingering concerns about the status of GAD as an independent disorder have conspired to exacerbate the problems surrounding the current diagnostic criteria, resulting in some researchers advocating that all anxiety disorders should be referred to as "general neurotic disorder." Early clinical studies evaluating GAD, as described by the DSM-III, found that the condition was usually comorbid with another anxiety or mood disorder. Several researchers have argued that GAD might be better categorized as a prodrome, residual, or severity marker (Kessler et al., 2001a). The requirement that anxiety be excessive and persistent for a minimum of 6 months is the subject of most of this controversy. Recently, reported epidemiologic data also show that generalized anxiety syndromes that persist for a shorter period of time, and that are not excessive in relation to objective stressors, include a considerable proportion of psychosocially disabled individuals suffering as much impairment as those meeting full GAD criteria (Maier et al., 2000; Kessler and Wittchen, 2002). Interestingly, there is no comparable DSM requirement that