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Quality of life in geriatric generalized anxiety disorder: a preliminary investigation

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Abstract

Objective: To examine the impact of late-life generalized anxiety disorder (GAD) on health-related quality of life. *Method*: We compared quality of life in 75 treatment-seeking older adults with GAD, 39 of whom had psychiatric comorbidity, with 32 older adults without psychiatric illness. We examined predictors of quality of life in these samples. We also compared data from the GAD patients to published norms from a large national sample of older adults with chronic medical conditions or major depression. *Results*: Older GAD patients reported worse health-related quality of life across most domains than asymptomatic older individuals. There were no differences in quality of life between GAD patients with and without psychiatric comorbidity, and comorbidity did not predict quality of life in multivariate regression analyses. Presence of GAD or symptoms of anxiety or depression were significantly related to impairment in every domain of quality of life. Comparisons with national norms suggest that older GAD patients report overall worse quality of life than individuals with recent acute myocardial infarction or type II diabetes, and are comparable in quality of life to individuals with major depression. *Conclusion*: Results suggest that late-life GAD is associated with substantial impairment in quality of life, and these findings cannot be explained by psychiatric comorbidity.

Keywords: Generalized anxiety disorder; Aging; Elderly; Quality of life; Disability

1. Introduction

Current diagnostic criteria for generalized anxiety disorder (GAD) include at least six months of excessive, hard to control worry more days than not, along with at least three of the following associated symptoms: restlessness, sleep disturbance, fatigue, muscle tension, irritability, and impaired concentration (American Psychiatric Association, 1994). Existing evidence, although limited, suggests that GAD as defined by DSM criteria exists in late life and is similar in presentation to what is observed in younger adults (Beck et al., 1996; Wetherell et al., 2003). For example, features that distinguish older adults with GAD from both normal older adults and older adults with subsyndromal anxiety symptoms include frequency and uncontrollability of worry, muscle tension, and sleep disturbance, along with distress or impairment (Wetherell et al., 2003).

Although some have questioned the severity and functional impact of GAD (Akiskal, 1998), evidence is mounting that individuals with GAD experience increased disability and poorer mental health and well-being relative to individuals with no psychiatric illness (Blazer et al., 1991; Hunt et al., 2002; Jones et al., 2001; Wittchen et al., 1994). Several investigators have found that GAD comorbid with another disorder such as major depression is associated with increased functional impairment relative to that associated with either GAD or major depression alone (Judd et al., 1998; Kessler et al., 1999; Wittchen et al., 2000). Although the results of small investigations have suggested that the disability associated with pure GAD is less than that associated with other disorders (Olfson et al., 1997; Schonfeld et al., 1997), studies in larger and more representative samples have indicated that the level of disability associated with GAD alone is

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greater than or equal to that associated with other disorders such as major depression (Kessler et al., 1999; Massion et al., 1993; Ormel et al., 1994). These studies, however, did not focus on older adults, for whom comorbid medical illness and associated disability may cloud the evaluation of functional impairment associated with GAD.

Only a few investigations have examined the impact of anxiety disorders on disability or quality of life in older adults. In the Longitudinal Aging Study Amsterdam, De Beurs and colleagues found that anxiety disorders and symptoms, regardless of comorbidity with depression, were associated with poorer perceived health and more chronic physical illness, functional and activity limitations, days in bed, loneliness, and worse life satisfaction (De Beurs et al., 1999). Overall, these results suggest that anxiety is associated with both poor health and disability, but they do not provide evidence that anxiety-related disability is comparable to disability from medical illness or depression. A recent comprehensive review of the relationship between disability and anxiety and depression in late life concluded that anxiety has not yet been established as a risk factor for disability independent of depression (Lenze et al., 2001).

To our knowledge, only one study to date has examined quality of life in late-life GAD specifically. In a treatment-seeking sample of 59 older adults with GAD (aged 60–80 years), Bourland and colleagues found impairments in quality of life and life satisfaction relative to published data from samples of older adults and mixed age groups with no psychiatric disorder (Bourland et al., 2000). Quality of life in the older GAD patients was comparable to that in a published sample of younger adults with social phobia. Almost half of the older GAD sample had clinically significant depression; 32% had major depression and 10% had dysthymia, depressive disorder not otherwise specified, or adjustment disorder with depressed mood. In addition, a substantial proportion had other anxiety disorders such as social or specific phobia. The investigators found that severity of depressive and anxiety symptoms predicted quality of life in late-life GAD, and income and optimism predicted life satisfaction. The impact of physical health was not examined in these analyses.

In the present study, we investigated health-related quality of life in a small sample of older adults with GAD. We hypothesized that quality of life of older adults with GAD would be impaired relative to individuals without GAD and comparable to that of individuals with chronic physical illnesses or major depression. We further predicted that the presence of GAD and anxiety and depressive symptoms would be associated with worse quality of life across multiple domains, even after controlling for medical comorbidity.

2. Methods

2.1. Participants

Seventy-five older adults with GAD were recruited through hospital-affiliated health education programs, senior centers, and media advertisements to participate in a psychotherapy study (Wetherell & Gatz, 2001; Wetherell et al., 2003). Those with a history of mania or psychosis, cognitive impairment, current alcohol or substance abuse, or current participation in psychotherapy were excluded from participation. Individuals with comorbid psychiatric disorders were eligible to participate, as long as their principal (i.e., most severe) diagnosis was GAD. More than half of the sample ($n=39$) met criteria for another disorder. Comorbid diagnoses included specific phobia ($n=15$), depression ($n=14$), social phobia ($n=11$), panic disorder ($n=6$), posttraumatic stress disorder ($n=5$), obsessive-compulsive disorder ($n=4$) and hypochondriasis ($n=1$). Twenty-six of the 39 individuals with psychiatric comorbidity had one comorbid condition, 10 had two, two had three, and one had four. The other 36 GAD patients had no comorbid Axis I conditions.

This sample of older adults with GAD was compared with data from two other sources. First, a normal comparison sample of 32 older adults with no current experience of significant symptoms of any DSM-IV psychiatric disorder was recruited from the same sources as the GAD patients (Wetherell & Gatz, 2001; Wetherell et al., 2003). Second, health-related quality of life data from the older GAD patients were compared to published norms from the Medical Outcomes Study (Ware, 1993). Medical Outcomes Study norms have been used for comparison purposes in a number of other investigations (Simon et al., 2002; Singer et al., 1999). In the present study, comparison groups included individuals with recent acute myocardial infarction, type II diabetes mellitus, and major depression. These data were collected by mail from patients screened from February to October 1986 from the practices of 523 physicians and mental health providers in Boston, Chicago, and Los Angeles (Ware, 1993).

2.2. Procedures

All prospective participants underwent a 30-minute telephone screening. Those who reported symptoms consistent with GAD were invited to undergo an in-person diagnostic interview using the Anxiety Disorders Interview Schedule for DSM-IV (ADIS-IV; Di Nardo et al., 1994). A second rater reviewed 25 randomly selected audiotapes of diagnostic interviews; raw percent agreement on the GAD diagnosis was 88%, $\kappa=0.75$. Those with GAD who met criteria for the treatment outcome study and who agreed to participate returned for a sec-