

# The epidemiology of generalized anxiety disorder in Europe<sup>☆</sup>

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## Abstract

The objective of this paper is to provide a review on available data to date on the epidemiology of GAD in Europe, and to highlight areas for future research. MEDLINE searches were performed and supplemented by consultations with experts across Europe to identify non-published reports. Despite variations in the design of studies, available data suggest that (a) about 2% of the adult population in the community is affected (12-month prevalence), (b) GAD is one of the most frequent (up to 10%) of all mental disorders seen in primary care, (c) GAD is a highly impairing condition often comorbid with other mental disorders, (d) GAD patients are high utilizers of healthcare resources, and (e) despite the high prevalence of GAD in primary care, its recognition in general practice is relatively low. Marked data deficits are: lack of data from eastern European countries, lack of information about the natural course of GAD in unselected samples, the vulnerability and risk factors involved in the aetiology of GAD and lack of data about adequate and inappropriate treatments in GAD patients as well as the associated and societal costs of GAD.

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## 1. Introduction

Generalized Anxiety Disorder (GAD) is usually described as a “severe” and “chronic” anxiety disorder, which is treatable. Prior to 1980, when the diagnosis of GAD was first conceptualized in the DSM-III (APA, 1980), patients with GAD-like symptomatology were usually grouped along with patients with panic disorder-like manifestations under the diagnostic term “anxiety neurosis” — a diagnosis that is still more familiar to many clinicians than GAD in Europe. Since the inclusion of GAD in DSM-III, this

diagnosis has received considerable fundamental and clinical research interest (see e.g. Heimberg et al., 2004) and has also been studied in various epidemiological investigations in Europe. Furthermore, several psychological and pharmacological treatments for GAD have been developed and tested in clinical trials (see for review Huppert and Sanderson, 2002; Sussman and Stein, 2002) and a number of drugs have been approved for treatment of GAD (Ballenger et al., 2001).

Research progress, however, has been somewhat impeded by the changing diagnostic criteria for GAD over the past several decades. Specifically, diagnostic criteria of GAD have been changed substantially since 1980 in the subsequent DSM revisions, and even the current DSM-IV and the ICD-10 criteria for GAD differ considerably. These differences have had profound impact on findings from epidemiological studies, as will be discussed below. Changes to the content of the diagnostic criteria have occurred in the majority of domains, including: (i) the duration criterion for core symptoms have shifted from an initial 1-month (DSM-III, 1980) to a

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stricter 6-month criterion in DSM-III-R and DSM-IV (APA, 1994), (ii) the definition of anxious worrying as a core criterion is increasingly strict, and (iii) the type and number of associated GAD symptoms was considerably revised in DSM-IV (i.e., instead of a long list of predominant anxiety symptoms, there are now only a few symptoms mostly describing symptoms of hypervigilance, hyperarousal, and tension; symptoms reflecting autonomic hyperactivity were deleted). It should be noted, however, that this change was not made in the ICD-10, which continues to use a much broader spectrum of symptoms. The diagnostic hierarchy exclusion criteria used in DSM offer another source of potential confusion. These rules require that, when another Axis I disorder is present, the diagnosis of GAD should be made only when the focus of the anxiety is unrelated to the other disorder. In addition, GAD symptoms may not be due to the direct physiological effects of a substance or general medical condition, and they do not occur exclusively during a mood disorder, a psychotic disorder, or a pervasive developmental disorder.

Currently, the most widely used diagnostic criteria for GAD in clinical and research settings are DSM-IV. DSM-IV requires excessive and uncontrollable anxieties, worries, or tension about a number of everyday events; the anxious worrying must be associated with at least 3 vigilance or motoric symptoms and the symptoms must cause clinically significant distress or impairment in important areas of daily functioning. In addition, the DSM-IV exclusion criteria apply (see above). It should be noted that DSM-IV allows the GAD-diagnosis also to be made in children, requiring however only one – instead of three as required for adults – of the additional associated symptoms. In DSM-III and DSM-III-R, GAD in children and adolescents was labeled “overanxious disorder.” This diagnosis was removed from the DSM-IV and GAD is applicable to all age groups.

## 2. Aims and methods

This paper reviews European contributions to the epidemiology of GAD after to 1980, highlighting prevalence and incidence, as well as risk factors, comorbidity, associated impairment and treatment rates in community and clinical settings. Studies were identified using a MEDLINE search and with consultations with experts throughout Europe to identify additional studies. Studies were included if conducted after 1980, and if established diagnostic instruments based on criteria from DSM-III onwards or ICD-10 were used. It should be noted that since older DSM-III-based studies rely only on 1-month duration criteria, we report those DSM-III findings in brackets. The review also used unpublished data that have been provided from the EBC epidemiological panel (Wittchen and Jacobi, 2005).

## 3. Results

### 3.1. Lifetime and 12-month prevalence of GAD in the community

Table 1 summarizes the lifetime and 12-months prevalence findings for GAD for a total of 15 studies from 15 countries across the EU, of which one combines finding from several countries (ESEMED). This table provides diagnostic criteria, instruments used, sample size and prevalence estimates, as well as gender ratio. Prevalence estimates are reported for three time frames (i.e., lifetime, 12-month, and/or point prevalence). Point prevalence is reported only for a few studies.

Beyond the consistent finding of the preponderance of GAD among females, there appears to be some degree of heterogeneity in results across studies. Most of this variability is due to the use of different instruments and conventions across studies, although the majority used either the DIS or the CIDI. Taking these methodological differences into account, results show that studies using the short 1-month DSM-III criteria have extremely high lifetime rates of 19% and 21%. These two studies were conducted in Belgium (Baruffol and Thilmany, 1993) and Iceland (Stefansson et al., 1991) and they provided an interesting example of the dramatic effects of the shorter 1-month duration GAD definition when compared to the narrower 6-months' definitions of GAD in subsequent versions DSM-III-R/DSM-IV. Nevertheless, there is still remarkable variation between DSM-III-R- and DSM-IV-based studies when the longer 6-months requirement is considered. Excluding the Italian study due to use of a different instrument, the lifetime prevalence estimates of the remaining studies (including also the Wacker Study which applied additionally to DSM-IV the ICD-10 criteria) range between 0.1% and 6.4%. In contrast, DSM-III-R/DSM-IV 12-month prevalence/point estimates appear to be more consistent with the vast majority reporting rates between 0.8% to 2.1%. A similar degree of variability is evident for the four ICD-10-based studies, where 12-months/point estimates vary between 0.2% and 3.1%. The 12-month median across all studies is 1.7%, which could be considered as a best 12-month estimate. For lifetime prevalence, the female to male ratio ranges from 1.2 to a high of 13.8 and for 12-month prevalence from 1.2 to 3.9. Overall, these findings indicate a two- to three-fold increased risk of GAD for women compared to men.

### 3.2. Prevalence in primary care

GAD is among the few conditions which has also been studied in primary care settings. The international WHO multi-center study on Psychological Problems in General Health Care (PPGHC; 14 sites, Üstün and Sartorius, 1995), which included 6 EU-states revealed that approximately 7.9% of all consecutive primary care attenders met

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