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Age and racial differences in the presentation and treatment of Generalized Anxiety Disorder in primary care

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Abstract

Despite the prevalence and impact of Generalized Anxiety Disorder (GAD) in the primary care setting, little is known about its presentation in this setting. The purpose of this study is to examine age and racial differences in the presentation and treatment of GAD in medical patients. Participants were recruited from one family medicine clinic and one internal medicine clinic. The prevalence of GAD was lowest for older adults. Age differences were found in the presentation of GAD, with young adults reporting greater cognitive symptoms of anxiety, negative affect, and depressive symptoms. African-Americans with GAD reported more positive affect and lower rates of treatment. The lower levels of negative affect and depressive symptoms reported among older adults may affect the recognition of GAD by primary care physicians. Further research is needed to better understand the causes of racial differences in treatment.

Keywords: Age differences; Anxiety; Elderly; Generalized Anxiety Disorder; Racial differences

Generalized Anxiety Disorder (GAD) is characterized by excessive and uncontrollable worry lasting for at least 6 months and at least 3 of the following symptoms: feeling restless, keyed up, or on edge; fatigue; impaired concentration; irritability; muscle tension; and sleep disturbance (APA, 2000). Results of the National Comorbidity Survey-Replication (NCS-R) indicate a lifetime prevalence for GAD of 5.7% (Kessler et al., 2005). GAD is associated with both emotional and physical symptoms and impairments in quality of life; these impairments are comparable to those experienced by persons with major depression and physical conditions, and greater than those associated with substance abuse. It is also associated with significant economic burden, through higher use of medical services and missed workdays (for a review, see Hoffman, Dukes, & Wittchen, in press).

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Understanding GAD within the context of primary care settings is important. The prevalence of GAD is higher in the primary care setting than in community-based epidemiological studies, with rates as high as 14.8% (Olfson et al., 2000), and when anxiety is comorbid with a physical condition, even greater impairments in quality of life and disability result (Katon, Lin, & Kroenke, 2007; Sareen et al., 2006). Anxiety is characterized by a number of somatic symptoms which may be easily mistaken for a medical problem. Also, anxious patients in a primary care setting are likely to present with a complex constellation of symptoms, as anxiety is often associated with unexplained medical symptoms (Katon, Sullivan, & Walker, 2001; Kroenke et al., 1994). All of these factors contribute to the lack of recognition and undertreatment of anxiety in the primary care setting (Kessler, Lloyd, Lewis, & Gray, 1999; Lowe et al., 2003; Young, Klap, Sherbourne, & Wells, 2001).

Both age and race are important factors to consider when addressing anxiety. Anxiety confers additional burden on older adults, including incident mobility disability (Mehta et al., 2007), activities of daily living disability (Brenes et al., 2007), and even mortality (Brenes et al., 2005). Furthermore, African Americans are the largest minority group in the US yet little is known about racial differences in anxiety. African Americans are more likely to go to their primary care physician than a mental health specialist (Cooper-Patrick, Crum, & Ford, 1994), emphasizing the importance of understanding racial differences in this setting. Thus, identifying age and racial differences in anxiety in the primary care setting may aid in its recognition and treatment.

Results of epidemiological studies indicate that there are age differences in the prevalence of GAD. Data from the NCS-R indicate an increase in lifetime prevalence of GAD from young (4.1%) to middle adulthood (6.8–7.7%), with a decline in prevalence over the age of 60 years (3.6%; Kessler et al., 2005). Despite these differences in prevalence and the significant impact that GAD has on multiple domains of functioning, surprisingly little is known about possible age differences in the presentation of GAD.

There is evidence of age differences in the nature of anxiety in nonclinical samples (Lawton, Kleban, & Dean, 1993). Negative affect, which is hypothesized to be related to anxiety (Clark & Watson, 1991), declines with age (Charles, Reynolds, & Gatz, 2001), and some studies suggest age differences in the content and frequency of worry (Brenes, 2006; Diefenbach, Stanley, & Beck, 2001; Hunt, Wisocki, & Yanko, 2003; Powers, Wisocki, & Whitbourne, 1992). There may also be age related differences in the physiological symptoms associated with GAD, such as restlessness, fatigue, and tension, with older adults experiencing decreased physiological reactivity and/or tension to anxiety (Christensen et al., 1999; Kogan, Edelstein, & McKee, 2000). Physiological or somatic symptoms of anxiety may be less prominent in older adults (Depp, Woodruff-Borden, Meeks, Gretarsdottir, & DeKryger, 2005). However, given the prominence of somatic symptoms in the primary care setting, it is not known if this finding is also true for older adults with GAD presenting in the primary care setting.

Less is known about age differences with respect to treatment for anxiety. Effect sizes for cognitive-behavioral treatment of GAD are lower for older adults (Ayers, Sorrell, Thorp, & Wetherell, 2007), and use of benzodiazepines is disproportionately higher (Klap, Unroe, & Unutzer, 2003). Further, both young and old are less likely to receive appropriate treatment for anxiety than are middle-aged adults (Young et al., 2001). However, no one has examined this within the context of GAD.

Even less research has examined racial differences in GAD. Lifetime prevalence of GAD is lower in African-Americans than in whites (5.1% vs. 8.6%; Breslau et al., 2005; 3.0% vs. 4.6%; Grant et al., 2005). A similar pattern was reported for 12-month prevalence (1.9% vs. 2.2%, Grant et al., 2005). Although there is no evidence of racial differences in the frequency and intensity of worry in nonclinical samples (Gillis, Haaga, & Ford, 1995; Scott, Eng, & Heimberg, 2002), there are differences in the content of worries. African-Americans report fewer worries about relationships, lack of confidence, future, and work incompetence than Whites (Scott et al., 2002). Other evidence of racial differences are found in the context of panic attacks and panic disorder, with African-Americans reporting higher levels of phobic avoidance (Chambless & Williams, 1995), numbing and tingling, (Horwath, Johnson, & Hornig, 1993; Smith, Friedman, & Nevid, 1999), fears of dying and going crazy (Smith et al., 1999), and sleep paralysis (Bell & Jenkins, 1994). Similarly, racial differences exist with respect to treatment for anxiety disorders, with African-Americans being less likely than whites to receive appropriate treatment (Young et al., 2001). Racial differences in the presentation of anxiety may contribute to underrecognition and lack of treatment.

The present study furthers our understanding of age and racial differences in anxiety symptoms and GAD in the primary care setting by using a large sample of