Generalized Anxiety and Depression in Primary Care: Prevalence, Recognition and Management

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Introduction

Generalized Anxiety Disorder (GAD) and Major Depressive Episode (MDE) are both commonly occurring and impairing conditions that are characterized by low rates of treatment and by low rates of treatment adequacy. Much less attention has been paid to GAD either in the mass media or in the scientific literature, and it is a common belief that pure GAD (uncomplicated by depression) does not exist.

However, recognition and treatment of GAD are of special importance, because these patients often are high utilizers of primary care with low patient self-recognition of their symptoms as an emotional disorder, and there is only little empirical data available.

To obtain comprehensive data on prevalence, recognition and management of GAD vs. MDE in primary care the “Generalized Anxiety and Depression in Primary Care”-study (GAD-P, Wittchen et al., 2002) was carried out in a nationally representative sample of primary care doctors in Germany.

Methods

A) Sample: N=17739 patients from N=558 primary care doctors

A total of 558 doctors (response rate: 89%) took part in the study. This sample covers about 1% of all primary care physicians in Germany and can be regarded as representative in terms of geographic distribution, primary care function, patients per day, and years of clinical practice.

Full patient’s and doctor’s information for GAD and depression was available for 17,739 patients. Main reasons for exclusion of patients from the analyses were: age under 16, refusal to participate (mostly due to currently impairing medical conditions), missing data because doctors’ and patients’ identification codes did not match, and not completing all the diagnostic questions for GAD or MDE. Missing analysis: Although we adjusted for several effects found in a missing analysis by introducing weights, parallel analyses of the weighted and unweighted data yielded similar results.

Patient’s characteristics were representative for primary care in Germany: Age: 16 to 96 years (mean 50.3); Sex: 58.9% female, 41.1% male; Marital status: 59.5% married; Employment status: 45.7% employed, 31.1% unemployed/ retired, 11.0% homemakers; Most frequent primary reason for seeing the doctor: somatic complaint (38.3 %), pain (29.4 %), mental problems: 12.0% (anxiety, depression: 4.0%)

B) Assessment:

1. pre-study questionnaire on provider characteristics
2. patient’s self-report questionnaire including GAS-Q and DSQ
3. doctor’s clinical appraisal questionnaire for each patient including the doctor’s assessment of mental and physical problems and information about treatments provided

The screening instruments (GAS-Q, DSQ; Wittchen & Perkonigg, 1997) have good to excellent psychometric properties and served as the diagnostic “gold standard” for the presence of either DSM-IV GAD criteria.

Results

Table 1: Point prevalence (DSM-IV) of GAD (>1month) and MDE

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td>GAD/MDE diagnoses:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>neither GAD nor MDE</td>
<td>16023</td>
<td>90.3</td>
<td>6725</td>
</tr>
<tr>
<td>pure GAD</td>
<td>666</td>
<td>3.7</td>
<td>205</td>
</tr>
<tr>
<td>pure MDE</td>
<td>772</td>
<td>4.4</td>
<td>251</td>
</tr>
<tr>
<td>comorbid GAD / MDE</td>
<td>278</td>
<td>1.6</td>
<td>93</td>
</tr>
<tr>
<td>GAD symptoms:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>no generalized anxiety symptoms</td>
<td>12853</td>
<td>73.0</td>
<td>5753</td>
</tr>
<tr>
<td>generalized anxiety symptoms only</td>
<td>3842</td>
<td>21.7</td>
<td>1223</td>
</tr>
<tr>
<td>Total prevalence of GAD</td>
<td>944</td>
<td>5.3</td>
<td>298</td>
</tr>
</tbody>
</table>

Figure 1: Recognition rates: How often does the doctor recognize a case and how often does he diagnose correctly?

Discussion: Conclusions & Limitations

Conclusions:

1. About 10% of primary care patients meet criteria for current GAD or MDE ➔ relevance of these disorders in primary care
2. Only a minority of GAD patients had comorbid MDE ➔ GAD independent disorder in primary care; GAD-specific interventions needed (rather than symptom specific interventions)
3. Low self-recognition of patients ➔ Doctor’s education should be added by focus on direct-to-consumer education
4. GAD patients remain poorly recognized and treated !

Limitations:

5. Diagnoses of GAD and MDE were based on self report questionnaires rather than on interviews
6. Participating doctors were aware of the study focus on anxiety and depression ➔ about 30% correctly diagnosed GAD upper bound estimate
7. Follow up studies needed to judge adequacy of treatment