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Clinical Significance of Individual GAD Symptoms in Later Life

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Abstract

Background—There are age-related differences in the manifestation of generalized anxiety disorder (GAD) symptoms and their associated impact on psychosocial and functional status. However, it remains unclear whether specific symptoms (or symptom patterns) are of comparable clinical significance across different functional domains.

Methods—A sample of 865 self-reported worriers (aged 60 years and older) who endorsed GAD screening questions in the Alcohol Use Disorder and Associated Disabilities Interview Schedule, *Diagnostic and Statistical Manual of Mental Disorders, fourth edition*, were derived from Wave 1 of the National Epidemiological Survey of Alcohol and Related Conditions.

Results—Being easily fatigued was significantly associated with occupational disability and a functional disability variable (restricting usual activity in any way). Irritability was significantly associated with social friction (arguments with friends, family, or colleagues) and a functional disability variable (found was unable to do something wanted to do), and poor self-perceived health was also associated with the same functional disability variable. Excessive worry, despite being among the least reported symptoms, was significantly associated with distress.

Conclusions—These findings suggest that individual GAD symptoms are differentially associated with aspects of clinical significance relevant to daily life, such as social, occupational, and functional ability. The differential impact of individual symptoms on functional status may be diluted when using symptom sum scores. A nuanced approach to assessing the clinical significance of individual GAD symptoms in older adults may be fruitful for efforts aimed at early detection and treatment.

Keywords

anxiety; functional status; geriatric psychiatry

There are age-related differences in the presentation of generalized anxiety disorder (GAD) that may have a particular bearing on diagnosis and treatment in older adults. A diagnosis of

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GAD requires that its constituent symptoms be clinically significant (ie, associated with considerable distress and/or disability). In terms of GAD symptom patterns, relative to younger adults, older adults tend to report fewer worries, ascribe less functional value to worrying, utilize fewer coping strategies in an attempt to control their worries, and worry more about others than themselves.^{1–6} In terms of clinical significance, older adults are more vulnerable to physical disability and less vulnerable to emotional distress and negative affective states, suggesting that there may be age-related variables influencing the functional impact of GAD symptoms (ie, fewer symptoms may suffice to cause disability in older adults).^{7–9} Indeed, fewer symptoms have been found to distinguish older adults with threshold and subthreshold GAD, older adults with threshold and subthreshold GAD have been found to share similarities in terms of health-related characteristics, and anxiety-associated disability observed in older adults with GAD has been found to persist longitudinally despite the waning of symptoms.^{10–12} However, most studies assessing the impact of GAD symptoms have to date relied on symptom sum scores, and the influence of individual GAD symptoms on clinical significance variables therefore remains unclear. The purpose of this study was to determine whether aspects of clinical significance associated with late-life GAD would be accounted for on the basis of unique symptom patterns.

Methods

Sample

The National Epidemiologic Survey of Alcohol and Related Conditions (NESARC) was conducted in 2001 to 2002 by the US Bureau of the Census and sponsored by the National Institute of Alcohol Abuse and Alcoholism (NIAAA). Forty-three thousand ninety-three adults were sampled from all 50 US States, and the District of Columbia. African Americans, Hispanics, and young adults were purposively oversampled, and the overall response rate was 81%. Data were adjusted for oversampling and nonresponse. Face-to-face interviews were conducted by trained lay interviewers using the Alcohol Use Disorder and Associated Disabilities Interview Schedule, *Diagnostic and Statistical Manual of Mental Disorders, fourth edition*, version (AUDADIS-IV, DSM-IV), which has been found to have good psychometric properties.^{13,14} Specifically, GAD symptoms were found to have very good reliability, and the GAD diagnostic variable was found to be fairly reliable.¹³ All participants aged 60 years and older who endorsed at least 1 of the 2 screening questions for the GAD portion of the interview were included in this study because those who did not endorse the screening questions were not further assessed for the GAD portion of the interview. The 2 screening questions were: “Ever had a 6+ month period during which you felt: (a) tense/nervous/worried most of the time or (b) very tense/ nervous/worried most of the time about everyday problems?” The overall sample consisted of 865 participants (aged 60–98 years), representing approximately one-fourth of the overall sample of self-reported worriers. In other words, about 25% of all self-reported worriers in the overall NESARC sample were aged 60 years or older.

Measures

Sociodemographic and health variables were accounted for in all analyses. These consisted of gender, education (some college or higher, completed high school, less than high school),

personal income (US \$0–US \$9999, US \$10 000–US \$34 999, US \$35 000+), marital status (married/cohabiting, widowed/divorced/separated, never married), urbanicity (urban, rural), self-perceived health (excellent, very good, good, fair, poor), and presence of chronic medical conditions (0, 1, or 2 or more; selected from a finite list of 11 variables including arteriosclerosis, hypertension, liver cirrhosis, liver disease, angina pectoris, tachycardia, myocardial infarction, heart disease, stomach ulcer, gastritis, or arthritis). Participants were also characterized with respect to current and lifetime anxiety disorders (not including GAD), current and lifetime mood disorders, and personality disorders, all based on the AUDADIS-IV. The participants in this study, who endorsed at least 1 of the 2 GAD screening questions, could be conceptualized as having 12-month threshold or subthreshold GAD (consistent with previous studies).^{11,12} The sociodemographic and health variables of this sample are summarized in Table 1.

The following 10 core GAD symptoms included were excessive worry (ever think your worrying was excessive?), difficulty controlling worry (ever find it difficult to stop being tense/nervous/worried?), restlessness (often became so restless you fidgeted, often paced, or couldn't sit still), feeling keyed up or on edge (often felt keyed up or on edge), being easily fatigued (often got tired easily), difficulty concentrating (often had trouble concentrating/keeping mind on things), mind going blank (often had times when forgot what talking about/mind went blank), irritability (often felt irritable), muscle tension (often had tense, sore, or aching muscles), and sleep disturbance (often had trouble falling/staying asleep). All symptoms were obtained from the GAD portion of the AUDADIS-IV. Participants who met symptom criteria and reported occurrence in the past year were given a 12-month DSM-IV GAD diagnosis.

Five self-reported symptoms relevant to the clinical significance criterion, derived from the same portion of the interview, were also included: distress (felt uncomfortable about feeling nervous/anxious or by any of those things going on at the same time), social friction (had arguments/friction with family, friends, people at work, or anyone else), occupational disability (had difficulty doing things supposed to do—working, schoolwork, taking care of house/family), and 2 functional impairment variables (A: restricted usual activity in any way; B: found was unable to do something wanted to do).

Statistical Analyses

Five sets of weighted binary logistic regression analyses were conducted, in which each of the clinical significance variables served as the outcome variable of interest. Predictor variables included each of the sociodemographic, health, and symptom variables. An additional weighted binary logistic regression analysis was conducted, in which 12-month GAD diagnostic status (threshold or subthreshold) was the outcome variable, and predictor variables included sociodemographic, health, comorbidity, and clinical significance variables. Due to the inclusion of a large number of variables, significance levels were reset to $P < .01$ in each of the analyses to account for type 1 error. Sampling weights were used to adjust for oversampling and nonresponse and were based on census data. All statistical analyses were conducted using Stata 12.0, and survey commands consisted of primary

sampling units, probability weights, and strata with only 1 sampling unit centered at the overall sample mean (rather than the stratum mean).

Results

Individual GAD Symptom Frequencies

Figure 1 displays the weighted proportion (and 95% confidence intervals [CIs]) of participants endorsing each symptom. The 5 most frequently reported symptoms, with affirmation from 50% or more of all self-reported worriers, were difficulty controlling worry (0.69; 95% CI: 0.65–0.72), being easily fatigued (0.61; 95% CI: 0.56–0.65), feeling keyed up or on edge (0.54; 95% CI: 0.50–0.58), experiencing sleep disturbance (0.52; 95% CI: 0.48–0.56), and difficulty concentrating (0.51; 95% CI: 0.47–0.55). Interestingly, one of the key symptoms for meeting GAD criteria, excessive worry (0.33; 95% CI: 0.29–0.37), was among the least reported symptoms.

Individual Clinical Significance Variable Frequencies

Figure 2 displays the weighted proportion (and 95% CIs) of participants endorsing each functional impact variable. About half of all self-reported worriers reported being distressed (0.51; 95% CI: 0.46–0.56) and about a quarter of all participants reported experiencing social friction (0.30; 95% CI: 0.25–0.35).

Symptoms Associated With Clinical Significance Variables

In general, different individual symptoms were found to be associated with different functional impact variables (See Table 2). Excessive worry was significantly associated with distress (odds ratio [OR]: 2.12; 95% CI: 1.31–3.42). Irritability was significantly associated with social friction (OR: 3.38; 95% CI: 2.00–5.71). Being easily fatigued was significantly associated with occupational disability (OR: 2.50; 95% CI: 1.40–4.47) and functional disability (restricted usual activity in any way; OR: 2.43; 95% CI: 1.34–4.41). Irritability was significantly associated with another functional disability variable (found was unable to do something wanted to do; OR: 1.87; 95% CI: 1.20–2.92).

Clinical Significance Variables Associated With Diagnostic Status

An additional binary logistic regression analysis was conducted in order to assess whether any clinical significance variables would distinguish those with threshold and subthreshold GAD (see Table 3). Only a concurrent 12-month diagnosis of any mood disorder was found to significantly distinguish both groups (OR: 6.61; 95% CI: 2.96–14.77), such that a higher proportion of those with GAD had a comorbid mood disorder.

Discussion

In this study, proportions of old-aged self-reported worriers endorsing each of the 10 symptoms typically associated with a DSM-IV GAD diagnosis were estimated. Intriguingly, 1 of the 3 core GAD symptoms—excessive worry—was among the least reported symptoms. However, difficulty controlling worry was endorsed by the highest proportion of participants. These findings are consistent with those of previous studies, reporting that

uncontrollability, but not excessiveness of worry, may better represent a core feature of GAD.^{15,16} The third core symptom of GAD (ie, 6 or more months of worry on more days than not) was not included in these analyses because this question was used to determine the present sample (owing to a design feature of the NESARC). Being easily fatigued, feeling keyed up or on edge, experiencing sleep disturbance, and difficulty concentrating were among the most highly reported symptoms, with affirmation from at least half of all participants. These symptoms may be due to or exacerbated by normal aging, cognitive decline, or comorbid physical and psychiatric conditions (ie, depression or cognitive impairment). Given the lack of an asymptomatic comparison group, and the binary responses required for these variables, the present study was unable to determine the extent to which these symptoms are exacerbated by a GAD diagnosis.

Next, the proportion of old-aged self-reported worriers who endorsed each of the 5 functional impact variables was estimated. Distress and 1 of the 2 functional disability variables were found to be the most extensively reported, with affirmation from nearly half of all participants. Occupational disability and social friction were the least frequently reported. At first glance, the finding that distress was the most highly rated of all functional impact variables appears to be inconsistent with previous findings, suggesting that emotional experience improves with age.⁸ However, given that this study exclusively included participants who reported that they had experienced at least 6 months of worry, it would perhaps be more surprising if distress was not so highly rated. Although older adults are generally less prone to experiencing negative affective states, due in large part to improved emotional regulation, there are within-group individual differences such that some older adults remain susceptible to experiencing persistent and chronic negative states (eg, worry and anxiety).¹⁷

Finally, this study aimed to determine whether specific symptoms, or symptom patterns, would consistently be associated with various clinical significance variables. We hypothesized that different symptoms (or symptom clusters) would account for different clinical significance variables. In general, the findings of this study supported our hypothesis. A different pattern of symptoms was associated with each functional impact variable, the only exceptions being occupational disability and a functional disability variable (restricting usual activity in any way), which were accounted for by “being easily fatigued.” Despite the observation that excessive worry was found to be among the least frequently reported symptoms by this sample, it was the only variable that was significantly associated with distress. These findings are somewhat consistent with those of a previous study, which reported that participants who did not meet the excessiveness criterion for GAD had a slightly less extreme manifestation of anxiety (despite comparability on a number of other variables).¹⁵ However, at least among the older adults in this sample, excessive worry was significantly associated with distress despite being infrequently reported.

These findings are also consistent with previous studies, which indicate that individual symptoms, and symptom patterns, associated with late-life GAD (and with psychiatric disorders in general) have differential influences on diagnostic outcomes.¹² Individual symptoms appear to have different risk factors that may be diluted using sum scores.¹⁸ For

example, a recent study on depressed individuals found that individual symptoms have differential impacts on psychosocial outcomes.¹⁹ Focusing on aspects of psychosocial outcomes associated with individual symptoms may be a fruitful approach for improving conceptualization, identification, and treatment of GAD in later life as well. Our findings suggest that specific physiological (eg, being easily fatigued) and emotional (eg, irritability) symptoms, in addition to worry, are associated with specific functional status variables among those with threshold and subthreshold GAD. Like depression, GAD could be conceptualized as being composed of symptom clusters that may be a cause or consequence of each other.²⁰ Older age appears to bring about some regular changes in the manifestation of these symptoms, such that physical symptoms become more highly prevalent in the context of GAD.⁵ However, these changes may be due to a mix of age effects and comorbid physical and psychiatric conditions, and the interactions between these symptoms are less well known. Specifically, more work is needed to understand the interplay between physical symptoms and worry in later life and the mechanisms by which physical symptoms may exacerbate GAD outcomes. Nonetheless, these findings cast doubt on solely worry-based assessment for detecting GAD and the efficacy of cognitive interventions for treating late-life GAD (which have been found to be at best moderately effective).^{21–23}

Interestingly, there were no significant differences between the proportion of older adults with threshold and subthreshold GAD endorsing any of the clinical significance variables. These findings are consistent with previous studies indicating that there are relatively marginal differences between older adults with threshold and subthreshold GAD.^{10–12} However, it is important to note that clinical significance variables required binary responses (yes or no). Therefore, it was not possible to determine whether there were differences in the severity of distress or specific disability variables with respect to diagnostic status. Relative to the subthreshold group in this study, however, a significantly higher proportion of those with a diagnosis of GAD met criteria for a concurrent mood disorder. There are additional limitations with the present study that must be accounted for. As noted, the design of the NESARC prevented any comparison between self-reported worriers and an asymptomatic group. Thus, it was not possible to completely disentangle normal age effects from the unique influence of anxiety on symptom presentation and associated clinical significance variables. Second, the findings are based on cross-sectional associations, and therefore, causality could not be determined. Third, responses to all variables were obtained through self-report. Although self-report is effective for the identification of subjective symptoms, informant report is more effective for identifying the severity of observable symptoms.²⁴ Despite these limitations, we believe this study provides an important first step toward understanding the functional impact of individual GAD symptoms in later life. Future studies investigating longitudinal changes in symptom patterns and their functional impact will play an important role in improving conceptualization of late-life GAD.

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Figure 1. Weighted proportion (and 95% confidence interval [CI] bars) of core generalized anxiety disorder (GAD) symptoms endorsed by self-reported worriers.

Figure 2. Weighted proportion (and 95% confidence interval [CI] error bars) of clinical significance variables endorsed by self-reported worriers. Functional disability A refers to participants reporting that their usual activities were restricted, and functional disability B refers to participants reporting that they were unable to do something that they wanted to do.

Table 1Sociodemographic Characteristics of Self-Reported Worriers Aged 60 Years and Older.^a

Raw Frequencies (and Weighted Proportions)	
Age	71.18 ± 8.38
Sex	
Male	250 (33%)
Female	615 (67%)
Education	
Some college or higher	265 (27%)
Completed high school	269 (34%)
Less than high school	331 (39%)
Personal income	
US \$35 000+	193 (24%)
US \$10 000–US \$34 999	349 (39%)
US \$0–US \$9999	323 (37%)
Marital status	
Married	317 (51%)
Widowed/divorced/separated	506 (45%)
Never married	42 (4%)
Urbanicity	
Urban	188 (24%)
Rural	677 (76%)
Self-perceived health	
Excellent	79 (9%)
Very good	159 (19%)
Good	236 (29%)
Fair	220 (25%)
Poor	171 (19%)
Chronic medical conditions	
None	147 (18%)
One	231 (28%)
Two or more	487 (54%)
Current anxiety	
No	712 (83%)
Yes	153 (17%)
Current mood	
No	666 (78%)
Yes	199 (22%)
Lifetime anxiety	
No	605 (69%)
Yes	260 (31%)
Lifetime mood	

Raw Frequencies (and Weighted Proportions)	
No	451 (53%)
Yes	414 (47%)
Lifetime personality	
No	661 (77%)
Yes	204 (23%)

^aWeighted percentages are rounded and do not always add to 100.

Table 2

Binary Logistic Regression Analyses With Clinical Significance Measures as the Outcome Variables and DSM-IV GAD Variables as Predictors.^a

Odds Ratios (and 95% CIs)					
	Distress	Social Friction	Occupational Disability	Functional Disability A	Functional Disability B
Age	0.98 (0.95–1.00)	0.97 (0.95–1.00)	0.99 (0.97–1.02)	1.00 (0.98–1.03)	1.02 (0.99–1.05)
Gender					
Male	<i>b</i>	<i>b</i>	<i>b</i>	<i>b</i>	<i>b</i>
Female	0.82 (0.48–1.41)	0.73 (0.41–1.31)	0.79 (0.46–1.37)	0.59 (0.35–0.99)	0.50 (0.28–0.91)
Education					
Some college or higher	<i>b</i>	<i>b</i>	<i>b</i>	<i>b</i>	<i>b</i>
Completed high school	0.88 (0.48–1.63)	1.45 (0.71–2.95)	1.18 (0.74–1.89)	0.96 (0.60–1.55)	0.91 (0.53–1.54)
Less than high school	1.30 (0.66–2.55)	2.66 (1.22–5.81)	1.32 (0.75–2.34)	1.67 (0.96–2.91)	1.32 (0.74–2.38)
Personal income					
US \$35 000	<i>b</i>	<i>b</i>	<i>b</i>	<i>b</i>	<i>b</i>
US \$10 000–US \$34 999	1.31 (0.70–2.46)	1.24 (0.65–2.35)	.85 (0.33–1.19)	2.05 (1.10–3.81)	1.24 (0.71–2.19)
US \$0–US \$10 000	1.63 (0.83–3.19)	1.93 (0.92–4.04)	1.10 (0.51–2.35)	0.12 (1.05–4.28)	1.89 (1.06–3.39)
Marital status					
Married/cohabiting	<i>b</i>	<i>b</i>	<i>b</i>	<i>b</i>	<i>b</i>
Widowed, divorced, separated	1.35 (0.83–2.20)	0.53 (0.31–.93)	0.84 (0.51–1.38)	1.03 (0.65–1.63)	1.04 (0.65–1.66)
Never married	2.06 (0.66–6.49)	0.71 (0.38–3.77)	0.66 (0.24–1.83)	0.42 (0.13–1.38)	0.31 (0.09–1.11)
Urbanicity					
Rural	<i>b</i>	<i>b</i>	<i>b</i>	<i>b</i>	<i>b</i>
Urban	1.07 (0.66–1.73)	1.04 (0.59–1.84)	1.59 (0.97–2.62)	1.78 (1.12–2.84)	1.32 (0.82–2.10)
Self-perceived health					
Excellent	<i>b</i>	<i>b</i>	<i>b</i>	<i>b</i>	<i>b</i>
Very good	0.74 (0.30–1.83)	1.64 (0.57–4.76)	0.76 (0.30–1.94)	1.38 (0.59–3.18)	2.32 (0.91–5.94)
Good	1.07 (0.44–2.59)	2.08 (0.76–5.65)	0.95 (0.38–2.39)	1.49 (0.59–3.72)	2.29 (0.86–6.13)
Fair	1.02 (0.43–2.41)	1.88 (0.63–5.58)	1.30 (0.50–3.35)	1.65 (0.64–4.25)	3.19 (1.21–8.40)
Poor	0.88 (0.33–2.33)	2.06 (0.62–6.82)	1.65 (0.66–4.09)	1.82 (0.74–4.48)	4.81 (1.78–13.02) ^c
Chronic medical					

Odds Ratios (and 95% CIs)					
	Distress	Social Friction	Occupational Disability	Functional Disability A	Functional Disability B
None	<i>b</i>	<i>b</i>	<i>b</i>	<i>b</i>	<i>b</i>
One	0.97 (0.46–2.05)	1.16 (0.49–2.76)	0.97 (0.43–2.16)	0.57 (0.29–1.12)	0.85 (0.40–1.79)
Two or more	1.13 (0.55–2.35)	1.31 (0.57–3.03)	1.17 (0.56–2.47)	0.99 (0.53–1.83)	0.87 (0.44–1.73)
Difficulty controlling worry					
No	<i>b</i>	<i>b</i>	<i>b</i>	<i>b</i>	<i>b</i>
Yes	1.11 (0.71–1.73)	1.08 (0.64–1.83)	1.30 (0.73–2.32)	1.13 (0.64–1.98)	1.06 (0.60–1.88)
Excessive worry					
No	<i>b</i>	<i>b</i>	<i>b</i>	<i>b</i>	<i>b</i>
Yes	2.12 (1.31–3.42) ^c	1.03 (0.63–1.68)	1.18 (0.76–1.84)	0.80 (0.49–1.29)	1.02 (0.64–1.63)
Easily fatigued					
No	<i>b</i>	<i>b</i>	<i>b</i>	<i>b</i>	<i>b</i>
Yes	1.89 (1.18–3.04)	1.49 (0.81–2.75)	2.50 (1.40–4.47) ^c	2.43 (1.34–4.41) ^c	2.15 (1.21–3.80)
Muscle tension					
No	<i>b</i>	<i>b</i>	<i>b</i>	<i>b</i>	<i>b</i>
Yes	1.03 (0.67–1.58)	0.82 (0.47–1.41)	0.65 (0.41–1.04)	1.38 (0.88–2.16)	1.16 (0.79–1.90)
Restless					
No	<i>b</i>	<i>b</i>	<i>b</i>	<i>b</i>	<i>b</i>
Yes	1.23 (0.72–2.11)	1.31 (0.79–2.16)	1.63 (1.06–2.49)	1.58 (0.97–2.57)	1.20 (0.75–1.92)
Keyed up or on edge					
No	<i>b</i>	<i>b</i>	<i>b</i>	<i>b</i>	<i>b</i>
Yes	1.29 (0.77–2.17)	1.76 (0.95–3.26)	0.82 (0.46–1.44)	1.13 (0.64–2.00)	1.03 (0.62–1.71)
Difficulty concentrating					
No	<i>b</i>	<i>b</i>	<i>b</i>	<i>b</i>	<i>b</i>
Yes	0.97 (0.59–1.57)	1.45 (0.77–2.75)	1.66 (0.96–2.87)	1.08 (0.68–1.72)	1.58 (0.98–2.53)
Irritability					
No	<i>b</i>	<i>b</i>	<i>b</i>	<i>b</i>	<i>b</i>
Yes	1.88 (1.13–3.14)	3.38 (2.00–5.71) ^d	1.84 (1.12–3.02)	1.71 (1.05–2.79)	1.87 (1.20–2.92) ^c
Sleep disturbance					
No	<i>b</i>	<i>b</i>	<i>b</i>	<i>b</i>	<i>b</i>

Odds Ratios (and 95% CIs)					
	Distress	Social Friction	Occupational Disability	Functional Disability A	Functional Disability B
Yes	1.18 (0.72–1.93)	1.45 (0.91–2.29)	0.98 (0.58–1.64)	1.02 (0.63–1.63)	1.50 (0.95–2.37)
Mind going blank					
No	<i>b</i>	<i>b</i>	<i>b</i>	<i>b</i>	<i>b</i>
Yes	1.49 (0.97–2.29)	.83 (0.48–1.42)	1.46 (0.92–2.32)	0.90 (0.58–1.40)	1.21 (0.77–1.89)
	$F_{(25,4)} = 0.41$	$F_{(25,5)} = 0.44$	$F_{(25,5)} = 0.43$	$F_{(25,5)} = 0.38$	$F_{(25,5)} = 0.66$
	VIF: 1.34	VIF: 1.34	VIF: 1.34	VIF: 1.34	VIF: 1.34

Abbreviations: GAD, generalized anxiety disorder; VIF, Variance Inflation Factor.

^aFunctional disability A: “restricted usual activity in any way”; functional disability B: “found was unable to do something wanted to do.”

^bReference category.

^c $P < .01$.

^d $P < .0001$.

Table 3

Binary Logistic Regression Distinguishing Subthreshold and Threshold GAD With Clinical Significance Variables as Predictors.^{a,b}

Age	0.99 (0.96–1.03)
Gender	
Male	<i>c</i>
Female	1.98 (0.97–4.06)
Education	
Some college or higher	<i>c</i>
Completed high school	1.15 (0.60–2.18)
Less than high school	1.19 (0.65–2.17)
Personal income	
US \$35 000	<i>c</i>
US \$10 000–US \$34 999	0.78 (0.36–1.71)
US \$0–US \$10 000	1.84 (0.87–3.90)
Marital status	
Married/cohabiting	<i>c</i>
Widowed, divorced, separated	1.09 (0.60–2.00)
Never married	1.80 (0.45–7.29)
Urbanicity	
Rural	<i>c</i>
Urban	1.21 (0.68–2.16)
Self-perceived health	
Excellent	<i>c</i>
Very good	1.55 (0.35–6.86)
Good	1.74 (0.43–7.13)
Fair	1.92 (0.46–8.02)
Poor	2.42 (0.60–9.73)
Chronic medical conditions	
None	<i>c</i>
One	0.84 (0.30–2.32)
Two or more	0.83 (0.33–2.05)
Current anxiety disorder	
No	<i>c</i>
Yes	1.73 (0.68–4.37)
Current mood disorder	
No	<i>c</i>
Yes	6.61 (2.96–14.77) ^d
Lifetime anxiety disorder	
No	<i>c</i>
Yes	0.73 (0.29–1.83)
Lifetime mood disorder	

No	<i>c</i>
Yes	0.49 (0.22–1.09)
Lifetime personality disorder	
No	<i>c</i>
Yes	1.32 (0.71–2.44)
Distress	
No	<i>c</i>
Yes	1.62 (0.87–3.04)
Social friction	
No	<i>c</i>
Yes	0.96 (0.50–1.81)
Occupational disability	
No	<i>c</i>
Yes	1.20 (0.60–2.40)
Functional disability A	
No	<i>c</i>
Yes	1.20 (0.60–2.40)
Functional disability B	
No	<i>c</i>
Yes	1.79 (0.89–3.60)
	$F_{(25,6)} = 0.63$
	VIF: 1.30

Abbreviations: GAD, generalized anxiety disorder; VIF, Variance Inflation Factor.

^aValues are presented as odds ratios (and 95% confidence intervals).

^bFunctional disability A: “restricted usual activity in any way”; functional disability B: “found was unable to do something wanted to.”

^cReference category.

^d $P < .0001$.