The importance of detecting anxiety in primary care

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In addition to validating the Malay version of the GAD-7, the study by Sidik and colleagues reinforces the importance of anxiety in primary care.[1] In contrast to the emphasis for the past several decades on detecting and treating depression, anxiety disorders have received far less attention despite their prevalence and associated disability. In one large survey of 1577 primary care patients, 12.1% had anxiety only, 4.4% had depression only, and 8.5% had both anxiety and depression.[2] Thus, a programme that screens only for depression may miss half of the patients with anxiety. Moreover, anxiety has an independent adverse effect on patient functioning and quality of life and may decrease the responsiveness of depression to treatment. Additionally, anxiety disorders can be effectively treated in primary care.[3] The evidence supporting the use of the GAD-7 as a brief anxiety measure has been recently reviewed,[4] and translations of the GAD-7, PHQ-9, and other related PHQ scales are freely available as public domain measures in numerous languages at www.phqscreeners.com.

Three aspects of the study by Sidik et al. warrant commentary. First, a GAD-7 cutpoint of 8 or above was selected as the threshold for anxiety. This is consistent with the original GAD-7 study, although a cutpoint of 10 or higher has been suggested as an alternative to decrease the number of false positive cases in some settings.[4] However, since the sensitivity found by Sidik was already lower than previously reported, the cutpoint of 8 appears appropriate for the clinic population in this study. Second, the proportion of primary care patients with a GAD-7 score of 8 or above was only 7% in this Malaysian study compared to 29% in the US primary care study.[5] In part, this may because, unlike the US study, patients with known psychiatric illness and those who were on psychoactive drugs were excluded. Third, it appears that all 38 of the 146 interviewed participants who had an anxiety disorder by the criterion standard Composite International Diagnostic Interview (CIDI) had Generalised Anxiety Disorder (GAD). In contrast, the US study, using the Structured Clinical Interview for DSM-IV Axis I Disorders (SCID) as the criterion standard interview, found that three other anxiety disorders had prevalences similar to GAD (7.6%), including post-traumatic stress disorder (8.6%), panic disorder (6.2%), and social anxiety disorder (6.2%).[6] Whether this is due to cultural differences in the prevalence of different anxiety disorders or differences in the way the CIDI and SCID were administered in the two studies is uncertain. It would be surprising if GAD was the only anxiety disorder present in Malay women with a GAD-7 score of 8 or above.

Finally, recognising that both anxiety and depressive symptoms frequently overlap with somatic symptoms is essential, especially since depressed or anxious patients commonly present in primary care with physical rather than emotional complaints. Indeed, co-occurrence of somatic, anxiety, and/or depressive symptoms (the 'SAD' triad) is more common than 'pure' forms of anxiety or depression alone.[7] Thus, assessing for both anxiety and depression with brief measures like the PHQ-9 and GAD-7 or even ultra-brief measures like the PHQ-4 (which includes two items each from the PHQ-9 and GAD-7) may be a useful step to improving the recognition and treatment of mental disorders in primary care.[2,4]

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