

Quality of life and disability in generalized anxiety disorder

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SUMMARY

Objective

To determine which clinical factors predict disability and poor quality of life in patients with generalized anxiety disorder.

Methodology

This was a descriptive, cross-sectional study. Data was analyzed using frequencies, percentages, and mean; a linear regression analysis was used to determine how demographic factors predict clinical disability and poor quality of life.

Results

We found that the presence of a family history of anxiety disorders, as well as higher scores on the Hamilton Depression Rating Scale predict a lower quality of life; unlike an older age which predicts a higher quality of life in these patients. Higher levels of disability were associated with male gender, younger age of patients, comorbid axis II disorders, presence of a family history of anxiety disorders, and higher scores on the Hamilton Depression Rating Scale.

Conclusions

Depressive symptoms and a family history of anxiety are associated with poor quality of life. Knowing which factors predict quality of life and disability in patients may guide us towards a more comprehensive diagnosis and treatment approach, and rather than just treating symptoms, seeking patients' functional recovery and quality of life.

Key words: Generalized anxiety disorder, quality of life, disability.

RESUMEN

Objetivo

Determinar qué factores clínicos predicen la discapacidad y la mala calidad de vida en pacientes con trastorno de ansiedad generalizada.

Material y métodos

Se trató de un estudio descriptivo y transversal. Los datos se analizaron mediante frecuencias, porcentajes y promedios. Se utilizó un análisis de regresión lineal para determinar cómo predicen los factores clínicos y demográficos la discapacidad y la mala calidad de vida.

Resultados

Encontramos que la presencia de antecedentes heredofamiliares de trastornos de ansiedad, así como mayores puntajes en la Escala de Depresión de Hamilton, predicen una menor calidad de vida, a diferencia de una mayor edad, la cual predice una mayor calidad de vida en estos pacientes. Mayores niveles de discapacidad se asociaron con el sexo masculino, una menor edad de los pacientes, comorbilidad con trastornos del Eje II, presencia de antecedentes heredofamiliares de trastornos de ansiedad y mayores puntajes en la Escala de Depresión de Hamilton.

Conclusiones

La sintomatología depresiva y los antecedentes familiares de ansiedad se asocian con una mala calidad de vida. Identificar estos factores en los pacientes podría guiar hacia un diagnóstico y tratamiento más integral y efectivo. Esto es, no sólo a tratar síntomas, sino a buscar una recuperación funcional y mejorar la calidad de vida del paciente.

Palabras clave: Trastorno de ansiedad generalizada, calidad de vida, discapacidad.

INTRODUCTION

Anxiety disorders are the most prevalent mental disorders, and they constitute a public health problem within society.¹ It is estimated that they have a global lifetime prevalence between 13.6% and 28.8% and a prevalence of 5.65% to 19.3% over the past 12 months. These ranges depend on the sample procedure, diagnosis instruments, and the

exclusion (or otherwise) of cases of anxiety secondary to a medical cause.²

According to the national survey of psychiatric epidemiology in Mexico, anxiety disorders have a prevalence of 14.3%. In the metropolitan areas of the country, greater prevalences of 3.4% were found.³

According to Virgen and Lara, there is a greater prevalence among 15 to 45 year olds in Mexico, with a greater

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proportion for women than men; two to one respectively. They commonly coincide with depressive disorders, meaning that treatment is delayed, which further complicates its management. Furthermore, the prognosis for anxiety disorders seems to be less favorable than for depressive disorders separately, which means that a return to adequate functioning is lower for these types of conditions.⁴

Generalized anxiety disorder (GAD) is characterized by the presence of excessive, permanent, and uncontrollable worrying related to multiple aspects of life, with muscular tension and autonomic hyperactivity.⁵ It was first introduced as a separate diagnostic category in the *DSM-III* in 1980.⁶

Patients with GAD primarily seek treatment due to alterations in sleep, muscular tension, dyspepsia, fatigue, or irritability, and not due to worry.⁷ This can bring difficulties in diagnosis, especially when considering that according to the *DSM-IV*, diagnosis of GAD cannot be made if medical conditions are present.²

The primary cognitive alterations associated with secondary somatic manifestations of anxiety alter the capacity for work and interpersonal relationships, as well as activities that bring pleasure. GAD also increases the risk of suffering from depressive episodes, somatic comorbidities, use of substances such as alcohol, and self-medication.⁷

Patients with this disorder present a distortion in their perception of risks and threats, particularly those concerning health, safety, and wellbeing of them as individuals or of close family members. The most frequent components of concerns according to the specialized literature are: family and interpersonal relationships, work, school, finances, and health.⁶

In terms of the sociodemographic characteristics of patients with GAD, it has been seen to be most frequent in young adults who have initial presentation ages ranging from 25 - 35 years of age. It is worth noting that the prevalence of this diagnosis increases with age, with no changes in those over 60.⁵ In terms of gender, higher rates have been seen in women with a ratio of 2:1. GAD is most frequent in people who are separated, as well as in subjects who are unemployed or of a low socio-economic level.⁸

The global annual prevalence of GAD has been reported between 3% and 8%.⁸ The prevalence of this disorder has been seen to vary in different countries, which is believed to be due to the low validity of its criteria.⁹ In Mexico, the 12-month prevalence has been reported from 0% to 4% in accordance with the national study on comorbidity in Mexico.¹⁰

GAD has a considerable negative impact on the daily life of patients, and on their functionality,¹¹ which links it to quality of life. The notion of quality of life can be considered as happiness or wellbeing. There are various definitions of quality of life, but the general consensus among researchers is that it refers to subjective wellbeing; a construct which is based on people's standards to determine what a good life is.¹² As such, quality of life is an overall assessment that

the subject makes of their life, and it depends both on the characteristics of the subject (demographics, personality, values, etc) as it does on external modulators, such as illness and any treatment required.¹³ The most useful assessments of quality of life should include, or at least differentiate between, subjective and objective estimations.¹⁴

Ware and Sherbourne described eight functional domains of quality of life associated with health: physical functioning, physical role, somatic pain, general health, vitality, emotional role, mental health, and social functioning.¹⁵

Disability is a dynamic concept that changed dramatically in the second half of the 20th century. The term has been defined in various ways, depending on the conceptual view, the intensity of the investigation, or the program's proposal. The cornerstone for understanding the transformation of the concept of disability was probably the WHO review of the classification system for disability.¹³

Substantial disability has been attributed to mental and neuropsychiatric disorders, which can cause the same, or even more incapacity than general medical conditions.¹⁶

As we can see in the work by Lara et al. around the quality of life associated with health in anxiety disorders, there has been a demonstrated association with disability in primary life roles, difficulties in relationships, a reduction in mental health and vitality, and poor physical functioning.¹³ Measuring function and wellbeing in subjects with anxiety disorders carries with it a more comprehensive assessment of the disorder and its treatment.

In spite of the interest around quality of life in patients with anxiety disorders having increased, research is still scarce. This is even more the case with disability in this type of patients. Quality of life and disability do not only influence the course of the illness, but also decisions on treatment and the response to the same. Studies which assess the relationship between quality of life and anxiety disorders are made as a group, not as independent diagnoses.

The importance of this research lies in two aspects. Firstly, there are no studies which measure both disability and quality of life in patients with GAD in the Mexican population. Secondly, it analyzes the majority of the factors related to quality of life and disability of these patients in the Mexican population. The aim of this research was to determine which clinical factors predict disability and poor quality of life in patients with GAD.

MATERIAL AND METHOD

This was a descriptive, cross-sectional study. The study was approved by the Ethics Committee at the National Institute of Psychiatry Ramón del la Fuente Muñiz (INPRFM). After this authorization, patients began to be included. Patients were included who had a diagnosis of GAD and who attended the INPRFM's Pre-Consultancy Service for treatment.

Patients were included who complied with the following inclusion criteria: 1. Men or women, 2. Aged between 18-65, 3. Met criteria for GAD according to *DSM-IV TR*, 4. Came to seek treatment from the INPRFM's Pre-Consultancy Service, 5. Knew how to read and write, 6. Agreed to participate and signed an informed consent form. Patients who had a learning or sensory disability, or psychotic symptomatology at the time of assessment were excluded.

Clinical measuring instruments

Mini International Neuropsychiatric Interview (MINI). This is a highly-structured diagnostic interview which is brief and applied by another person. It includes the primary Axis I psychiatric disorders from the *DSM-IV* and the *CIE-10*. There is a Spanish version by Ferrando and Bobes, with a Kappa reliability of >0.75 .¹⁷

Sheehan Disability Scale. This is an instrument to assess the level of disability of psychiatric patients. It consists of five items that are grouped into three scales: disability, perceived stress, and perceived social support. The first four items are scored on a Likert-type scale from 0 (absolutely not) through 10 (extremely). It does not provide defined operative criteria for the rest of the scales' values; rather, it considers 1-3 as "mild", 4-6 as "moderate", and 7-9 as "marked". Item 5 is scored on a percentage scale whereby 100% means that they have received all the support they need. It is a scale that can be self-applied as well as applied by another person. It gives three scores, one for each scale. The score for the disability scale is obtained by adding the scores for the three items that comprise it. There are no cutoff points; the higher the score, the greater the disability. The Spanish validation of this instrument was carried out by Bobes in 1999. It has a Cronbach's alpha value of 0.72, and a raised intra-class coefficient of correlation of 0.87, 0.63, and 0.75 for the total of incapacity, perceived stress, and perceived social support respectively.¹⁸

Endicott's Quality of Life Enjoyment and Satisfaction Questionnaire. This was developed in 1993. It is a self-applicable scale to explore the level of satisfaction experienced in quality of life in different dimensions. These dimensions are: physical health, subjective feelings, work, home activities, school work, activities during free time, social relationships, and general activities. It has 93 questions which are scored on a scale of 1 to 5. Reliability was assessed with the test-retest, and the instrument was applied on day 1 and 2. The results were an intra-class coefficient of correlation of 0.66-0.89 between the different dimensions. The internal consistency was assessed through Cronbach's alpha coefficient, giving results of 0.91-0.96 between the different dimensions.¹⁹

Hamilton Anxiety Rating Scale. This is a status scale with the objective of assessing the intensity of anxiety. It has a total of 14 items which assess the psychic, physical, and behavioral aspects of anxiety. It is applied by another person. It provides an overall measure of anxiety, obtained by add-

ing the scores for each one of the items. The recommended cutoff points are: 0-5: absence of anxiety. 6-14: mild anxiety. >15 : moderate/severe anxiety. The internal validity of the instrument indicates that it has two dimensions; psychic and somatic anxiety. On the other hand, the construct analysis, obtained by means of a factorial analysis, supports the idea of a psychiatric and a somatic factor.²⁰ The Spanish version was validated in 2002, obtaining a Cronbach's alpha of 0.89 and an inter-observer reliability over 0.9.²¹

Hamilton Depression Rating Scale. This is a scale applied by another person consisting of 21 questions. It is used to measure the severity of depression, and it serves to measure changes over time and response to treatment.

Construct analysis was carried out by means of a factorial analysis in 1972, finding a test-retest reliability of 0.82 and an internal consistency with a Cronbach's alpha coefficient of 0.73.²² This scale was validated in Spanish in 1986, with a Cronbach's alpha of 0.92 and an inter-rater reliability between 0.65 and 0.9.²³

Clinical demographic data sheet. This is a sheet on which a concentration of the clinical demographic data was carried out, obtained during the interview with patients.

Procedure

Patients were selected when attending to seek treatment from the INPRFM's pre-consultancy service, and by means of an open clinical interview, participants were selected with a diagnosis of GAD who met the inclusion and exclusion criteria. They were invited to participate and given informed consent forms to sign. An interview was carried out which confirmed the diagnosis with the MINI, and the concentration sheet for clinical demographic data was filled out. The Hamilton Anxiety and Depression Scales were then administered. Finally, the interviewees were given Sheehan's Disability Scale and Endicott's Quality of Life Enjoyment and Satisfaction Questionnaire to be filled out.

Statistical Analysis

For the description of the sample, frequencies and percentages were used for the categorical variables, and averages and standard deviation were used for the dimensional and quasi-dimensional variables. Linear regression analysis was used to determine how clinical and demographic factors predict disability and poor quality of life. Version 17 of the SPSS statistical package was used for the statistical analysis.

RESULTS

A total of 113 patients were included in this study. Some 69% were women with an age range of 18-64 years and an average age of 34.26 years. The rest of the sociodemographic

data is shown in Table 1. Some 57.5% of the sample were single people, with a period in education lasting an average of 12.5 years. Regarding occupation, we found that only 17.7% of the patients reported being unemployed.

The patients had an average onset age of 32.7 years (± 12.9) within a range of 10-62 years of age, and referred to the development time of the disorder as having an average of 25.5 months (± 28.0). The severity of anxiety was assessed through the Hamilton Anxiety Rating Scale, obtaining an average of 26.91 (± 6.95), and observing scores equal to or greater than 15 in 98% of the sample, which placed them at a moderate or severe level of anxiety (Table 1). The severity of depressive symptomatology was also assessed, and the average score of the Hamilton Depression Rating Scale was 15.10 (± 4.85) (Table 1).

In terms of comorbidity, 86% of the sample showed psychiatric comorbidity, of which 60.2% had a diagnosis, 17.7% had two diagnoses, and 8% had three or more diagnoses. The most frequent comorbid disorder was major depressive disorder, at 71.7%. Some 54% had a moderate major depressive episode; no severe cases were found (Table 2). Some 16% had medical comorbidity (Table 2).

Some 90.3% of patients referred to one or more stressful events being present. The most frequent stressful events were family stresses (38.93%) followed by partner and work stresses (24.7% and 16.81% respectively). Being a victim of violence during a lifetime had a prevalence of 38%, sexual violence being the most common at 46.51%.

Table 1. Clinical and sociodemographic data of patients with GAD

	Mean	S.D.	Range
Age	34.26	12.54	18-64
Education	12.50	3.99	3-23
Age of onset	32.70	12.90	10-62
Development time (months)	25.52	28.05	0-120
Endicott physical health	32.54	8.63	13-58
Endicott mental health	37.93	10.54	15-69
Endicott work	38.34	9.92	20-66
Endicott home	28.78	8.72	11-50
Endicott studies	30.00	10.31	12-49
Endicott free time	16.02	5.77	6-30
Endicott social	31.52	8.00	14-55
Endicott satisfaction	39.99	10.17	17-71
Endicott total	214.06	56.62	102-347
HAM-A	26.91	6.95	11-46
HAM-D	15.10	4.85	4-25
Sheehan work	6.02	2.88	0-10
Sheehan social life	6.69	2.84	0-10
Sheehan family life	6.34	2.83	0-10
Sheehan stress	7.29	2.42	0-10
Sheehan perceived social support	56.90	30.85	0-100
Sheehan total	26.35	9.23	2-40

GAD= Generalized Anxiety Disorder; Endicott= Endicott's Quality of Life Enjoyment and Satisfaction Questionnaire; HAM-A= Hamilton Anxiety Rating Scale; HAM-D= Hamilton Depression Rating Scale; Sheehan= Sheehan's Disability Scale.

Quality of life and disability

Quality of life was assessed in patients through the use of Endicott's Quality of Life Enjoyment and Satisfaction Questionnaire, which is divided into subscales and which does not have a cutoff point established for interpretation. It was therefore assessed taking into account the mean obtained for each subscale.

The subscale with the lowest score was that which measured free time, in which activities such as watching television, reading the paper or magazines, watering plants, visiting museums, or watching films or sports were assessed; here, 31.9% of the patients reported a low quality of life. This was followed by the subscale which assessed activities related to studying, in which 20.6% reported a low quality of life (Table 1).

Disability was measured with Sheehan's Disability Scale. Patients with GAD showed severe disability in the three areas of work, social life, and family (Table 3).

Prediction model

A linear regression model was used to analyze whether the clinical and sociodemographic data can predict disability and poor quality of life in these patients.

We found that the presence of a family history of anxiety disorders, as well as higher scores on the Hamilton Depression Rating Scale predict a lower quality of life; unlike an older age which predicts a higher quality of life in these patients (Table 4).

Table 2. Clinical characteristics of patients with GAD*

	Frequency (n)	Percentage (%)
Psychiatric comorbidity		
• None	16	14.2
• One	68	60.2
• Two	20	17.7
• Three	7	6.2
• Four	2	1.8
MDD severity		
• Absent	32	28.3
• Mild	20	17.7
• Moderate	61	54.0
Panic disorder	13	11.5
Dysthymia	6	5.3
Agoraphobia	9	8.0
Other	7	6.2
Substance dependency	20	17.6
Medical comorbidity		
• None	95	84.1
• One	14	12.4
• Two	3	2.7
• Three	1	.9

GAD= Generalized anxiety disorder; MDD= Major depressive disorder.

Table 3. Assessment of disability in patients with GAD*

	Sheehan work (n)	Sheehan social (n)	Sheehan family (n)
No disability	7.07% (8)	4.42% (5)	1.76% (2)
Mild disability	14.15% (16)	12.38% (14)	20.35% (23)
Moderate disability	23.89% (27)	21.23% (24)	20.35% (23)
Severe disability	46.01% (52)	42.47% (48)	47.78% (54)
Extreme disability	8.84% (10)	19.46% (22)	9.73% (11)

*GAD= Generalized anxiety disorder; Sheehan= Sheehan's Disability Scale.

Higher levels of disability were associated with male gender, younger age of patients, comorbid axis II disorders, presence of a family history of anxiety disorders, and higher scores on the Hamilton Depression Rating Scale (Table 4).

When analyzing predictors in the different subscales of Sheehan's Disability Scale, we could note that only the presence of comorbidity with axis II disorders, as well as higher scores on the Hamilton Depression Rating Scale, predict greater disability in the different categories.

This encapsulates that although the presence of a family history of anxiety disorder predicts a greater total disability, this does not happen on the subscale of work; on the other hand, on the subscale of social life, age is not a predictor of disability.

Patients who advised that they were married showed greater disability in the category of family life and in their perceived level of stress.

In the subscale of social support, it was found that only an older age showed a tendency for patients to refer to greater social support (Table 5).

In the different subscales of the Endicott Quality of Life Enjoyment and Satisfaction Questionnaire, according to the linear regression model, we observed that the only variable that was a predictor of low quality of life common to all the categories was the presence of higher scores in the Hamilton Depression Rating Scale (Table 6).

The presence of a family background of anxiety disorders predicted lower scores in the categories of physical health, mental health, free time, and satisfaction in patients with GAD. An older patient age predicted higher scores in the subscales which assessed social and working life. It is

worth noting that for the purposes of analysis, the subscales which assessed work, home, and study were joined together, giving the working subscale as a result (Table 6).

DISCUSSION

There are clinical and sociodemographic predictors for disability and a poor quality of life in patients with GAD. In this study, we could observe that the presence of a family history of anxiety disorders was an important predictor for both disability and a lower quality of life. According to the study by Rubio and López-Ibor, which carried out a 40 year follow-up of 59 patients with a diagnosis of GAD, 21% of the sample had a first-degree family member with a diagnosed anxiety disorder. Among these, the most common were specific phobia, panic disorder, and social phobia.²⁴

The presence and severity of depression were the most important variables which correlated both with disability as well as with lower rates of quality of life in these patients. Major depressive disorder occupies first place in terms of years of life affected by disability in Mexican women, and fifth place among men.²⁵ Due to these findings, we think that patients with GAD who attended the INPRFM probably seek treatment once comorbidity has established itself in the form of a major depressive episode. This would also explain why we could see such elevated rates of disability in these patients.

According to that reported by Tanja et al., this disorder is more frequently present in young adults with an age range of 25-35 years. In terms of sex, higher rates have been seen in women with a ratio of 2:1, as well as greater prevalence in

Table 4. Linear regression model*

	Variable	B	Beta	t	Sig.
Predictors of quality of life (Endicott Total)	(Constant)	.606		11.588	0.0000000
	Age	.002	.195	2.427	0.0168688
	FHAD	-.119	-.272	-3.329	0.0011882
	HAM-D	-.017	-.525	-6.546	0.0000000
Predictors of disability (Sheehan Total)	(Constant)	13.453		2.969	0.0036886
	Sex	4.923	.248	2.915	0.0043350
	Age	-.181	-.246	-2.895	0.0046025
	AXIS II	7.912	.244	2.924	0.0042148
	FHAD	5.219	.198	2.288	0.0241280
	HAM-D	.744	.391	4.542	0.0000147

FHAD= Family history of anxiety disorder; HAM-D= Hamilton Depression Rating Scale.

Table 5. Predictors of disability in the different Sheehan subscales*

	Variable	B	BETA	t	Sig.
Sheehan work	(Constant)	3.521		2.594	0.0108037
	Sex	1.554	.250	2.876	0.0048519
	Age	-.067	-.290	-3.365	0.0010595
	Axis II	1.961	.194	2.245	0.0268348
	HAM-D	.171	.288	3.306	0.0012870
Sheehan social life	(Constant)	1.366		1.053	0.2950000
	Sex	1.398	0.228	2.489	0.0140000
	Axis II	1.924	0.193	2.169	0.0320000
	FHAD	1.559	0.192	2.101	0.0380000
	HAM-D	0.205	0.351	3.768	0.0000000
Sheehan family life	(Constant)	4.662		3.505	0.0010000
	Sex	1.090	0.178	2.047	0.0430000
	Civil status	1.732	0.303	2.973	0.0040000
	Onset age	-0.087	-0.397	-3.910	0.0000000
	Axis II	2.460	0.247	2.837	0.0050000
	HAM-D	0.139	0.239	2.735	0.0070000
Sheehan perceived stress	(Constant)	5.097		4.505	0.0000000
	Age	-0.071	-0.365	-3.538	0.0010000
	Civil status	1.022	0.209	2.048	0.0430000
	Education	0.103	0.169	2.035	0.0440000
	Axis II	1.895	0.223	2.712	0.0080000
	FHAD	1.310	0.189	2.201	0.0300000
	HAM-D	0.168	0.337	4.096	0.0000000
Sheehan social support	(Constant)	39.706		4.194	0.0000554
	Education	1.375	.178	1.906	0.0592514

*Sheehan's Disability Scale.

single people;⁵ these findings were replicated in our sample.

One relevant point to note is the association that has been reported between the presence of GAD and low socio-economic levels, as well as greater levels of unemployment,⁸ given that more than 80% of patients in the sample advised having some form of occupation. This does not necessarily contradict the association previously described; rather, it may not be related to the characteristics of the population which comes to seek treatment at the INPRFM, which has higher rates of employment and more years in education. It should be noted that in this sample, the socio-economic level of the patients was not validated due to them being recruited in the Pre-Consultancy Service, which they attended subject to validation by social work.

In terms of the clinical characteristics of GAD, it has been seen that it has a chronic progression, which explains the mean development time in this sample of 25.52 months. In this sample, almost 9 out of every 10 patients with GAD had another psychiatric disorder, of which 3 out of every 4 patients had comorbidity with major depressive disorder. This is in accordance with that reflected in the data from the national comorbidity survey in 2004, which showed that 90% of the subjects with a diagnosis of GAD had at least one other comorbid disorder during their lifetime, while during the past month of development, the rate of comorbidity was 66%.²⁶

The high rates of comorbidity with major depressive disorder were interesting. One explanation that has been

given for this is the poor validity of the diagnostic criteria for GAD, given that as reported, they have very low specificity, overlapping with the diagnostic criteria for depression.² This comorbidity increases the individual and social economic burden, represents greater disability, and is more of a challenge in the treatment of these patients.²⁷

Among the triggers for GAD, we can see that in our sample, up to nine out of ten patients associate their anxiety disorder with the presence of stressors; a finding that suggests that environmental factors should be taken into account during the clinical evaluation and treatment of GAD patients.

According to a study carried out by Medina-Mora et al., 68% of the Mexican population has been exposed to at least one violent event in their life. Exposure varies by sex; rape, harassment, and sexual abuse were most frequent in women, and accidents and robberies were most frequent in men.²⁸ In this study, we could see a high prevalence of violence during a lifetime identified in one in three patients. Of these, 46.5% suffered sexual violence; this must be studied in greater depth, given that it has important implications for the mental health of the general population and possible prevention measures.

Mendlowicz and Stein carried out an epidemiological review of the clinical studies investigating quality of life in patients with anxiety disorders. They found that in comparison with those who did not have the disorder, patients with GAD received greater disability benefits during their lives. Even when they were found to be working, they showed

Table 6. Predictors of disability in the Endicott subscales

	Variable	B	BETA	t	Sig.
Physical health	(Constant)	0.623		13.040	0.0000000
	FHAD	-0.153	-0.323	-3.980	0.0000000
	HAM-D	-0.016	-0.474	-5.804	0.0000000
Mental health	(Constant)	.601		9.374	0.0000000
	Age	.005	.339	4.331	0.0000338
	FHAD	-.135	-.251	-3.281	0.0014014
	HAM-D	-.019	-.496	-6.514	0.0000000
Work*	(Constant)	0.494		6.818	0.0000000
	Age	0.005	0.346	3.937	0.0000000
	HAM-D	-0.013	-0.323	-3.697	0.0000000
Free time	(Constant)	0.707		9.761	0.0000000
	FHAD	-0.172	-0.250	-2.792	0.0060000
	HAM-D	-0.018	-0.354	-3.954	0.0000000
Social	(Constant)	0.598		8.402	0.0000000
	Age	0.003	0.237	2.145	0.0340000
	HAM-D	-0.014	-0.368	-4.157	0.0000000
Satisfaction	(Constant)	0.578		10.496	0.0000000
	FHAD	-0.082	-0.181	-2.166	0.0330000
	HAM-D	-0.020	-0.612	-6.109	0.0000000

*For the purposes of analysis, it was decided to join the subscales of work, home, and studies. PRVTT=Previous treatment; FHAD=Family history of anxiety disorders; HAM-D= Hamilton Depression Rating Scale.

indirect evidence of impediments.²⁹ This is also reflected in our study, as despite the majority of patients we assessed having some form of work, we could see that they present a greater percentage of disability. A lower quality of life in activities corresponding to free time could be giving us this indirect evidence of affectation in our patients.

One important aspect to note is the fact that in spite of a greater percentage of women in our study, men had higher levels of disability, even resulting as a predictor of the same. Scott et al. reported that in spite of women in the community having higher levels of disability due to mental illnesses, if men and women with an affective or anxiety disorder are compared, men show higher rates of disability, especially in activities relating to role, or social and cognitive activities.³⁰

Another important finding was the presence of a personality disorder, which was also seen as a predictor of disability in patients with GAD. This comorbidity was seen to be common, with up to 50% of GAD patients meeting criteria for a personality disorder. This is a rate comparable with that associated with other anxiety disorders. It will therefore be vitally important to carry out the diagnosis of these disorders in order to provide integrated treatment and so reduce the rates of disability in patients with GAD.²⁷

One of the limitations of the study was its descriptive and cross-sectional nature, which did not allow for cause and effect relationships. Another limitation is that it was carried out at the third level of care. We know that GAD is frequent in first-level or family medical centers, and the patients who attend third-level services such as the INPRFM probably have more complications, as they are referred from other treatment centers.

Among the advantages of this study is the way it assessed GAD individually and not within the group of anxiety disorders. It tried to include all the variables involved in the disorder and assessed both quality of life and disability in the same study.

This investigation encourages other comparative and follow-up studies to be carried out on GAD in the Mexican population, because as can be noted, it is a condition that causes disability and poor quality of life.

In conclusion, the socio-demographic characteristics of Mexican patients with GAD who attended the INPRFM in accordance with our study coincide with global-level data reported in the literature. This is extremely relevant, as these characteristics could possibly be extrapolated to the general Mexican population.

Knowing what factors predict quality of life and disability in patients could guide us towards comprehensive and effective diagnosis and treatment, not only of the symptoms, but also to seek patients' functional recovery and quality of life.

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