Content of Worry in the Community: What Do People With Generalized Anxiety Disorder or Other Disorders Worry About?

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In recent years, several studies have shown that generalized anxiety disorder (GAD) is associated with increased rates of comorbid mental disorder, social and occupational impairment, increased use of health services, and physical health problems among adults in the community (Kessler et al., 1999; Wittchen et al., 2000). High rates of comorbidity (Brawman-Mintzer et al., 1993; Sanderson and Wetzler, 1991) have led to ongoing debates over whether GAD is itself a disorder or is a syndrome that occurs only comorbid with other disorders (Kessler et al., 2001). Worry has been identified as the key pathological feature of GAD. Worry is common in the general population and is also associated in some form with other anxiety disorders, such as phobias, panic disorder, and GAD (Barlow, 1988; Barlow et al., 1986; Hoyer et al., 2002; Wells and Morrison, 1994). Available data on worry in GAD come almost exclusively from college student and clinical samples. Previous studies in clinical settings suggest that content and severity of worry among patients with GAD differ in specific ways from those among comparison groups, which have included healthy control groups (Craske et al., 1989; Roemer et al., 1997). For instance, previous studies suggest that patients with GAD have higher levels of worry over minor or routine matters compared with healthy control groups (Craske et al., 1989; Hoyer et al., 2001; Roemer et al., 1997; Shadick and Roemer, 1991). Nevertheless, Ruscio et al. (2001) come to the conclusion that content does not differ between patients and healthy controls. Furthermore, worries or intrusive thoughts seem to be related to higher levels of uncontrollability among those with GAD compared with those without (England and Dickerson, 1988; Hoyer et al., 2001; Parkinson and Rachman, 1981). The uncontrollability of worries is of particular interest from a clinical perspective, because it was added as criterion B in DSM-IV (American Psychiatric Association, 1994). Although previous studies have addressed the relationship between worry and GAD, several questions remain unanswered. First, although worry is considered a component of almost all anxiety disorders and affective disorders, no previous study has examined the degree to which worry is unique among those with GAD compared with those with other mental disorders. Second, there are no studies of worry in a community sample, because all data come from small clinical samples, and it is therefore not known to what extent these results are generalizable to the community. The goals of the current study are to begin to address these gaps.

METHODS

Design

The Dresden Study of mental health is a prospective epidemiological study designed to collect data on the prevalence, incidence, course, and risk factors of mental disorders. The results presented are from the baseline survey, which was conducted from July 1996 to September 1997.

Sample

The sample was drawn randomly from the Dresden government registry of residents. Participants were German women age 18 to 24 years at the time of sampling. Data from the 2064 women who were administered a structured clinical interview are reported here. Informed consent was obtained from all participants (for a more detailed description, see Becker et al., 2000).

Diagnostic Assessment

The diagnostic assessment was based on the Diagnostisches Interview für Psychische Störungen—Forschungsversion (F-DIPS; Margraf et al., 1996). The F-DIPS is a modified version based on the Diagnostisches Interview bei Psychischen Störungen (DIPS; Margraf et al., 1991) and the Anxiety Disorder Interview Schedule-Lifetime (ADIS-IV-L; Brown et al., 1994). It is a structured interview and allows for the standardized assessment of symptoms, syndromes, and diagnoses of a wide range of DSM-IV mental disorders, providing the interviewer with lifetime and point prevalence of disorders. In the present version, the interview contained a broadened section on worry, which also was maintained if participants did not fulfill initial GAD criteria (i.e., answered the stem questions of the GAD section positively).

Analytic Groups

To answer the research questions, the following categories of subjects were created. Subjects suffered from a) GAD at the time of interview (N = 37); b) anxiety disorders other than GAD at the time of interview (panic disorder without agoraphobia, panic disorder with agoraphobia, agoraphobia without history of panic disorder, social phobia, specific phobia, obsessive compulsive disorder, posttraumatic stress disorder; N = 316); c) mood disorders at the time of interview (major depressive disorder, dysthymic disorder, bipolar I disorder, cyclothymic disorder; N = 23); d) somato-
form disorders at the time of interview ($N = 21$); e) substance related disorders at the time of interview ($N = 14$); f) eating disorders at the time of interview ($N = 13$); or g) no mental disorder at the time of interview ($N = 1604$). If more than one disorder was present, subjects were assigned to only one category according to the following procedure: a) if GAD was present, the subject was assigned to the GAD group (regardless of the severity of the disorder); b) if disorders from different categories were present, the subject was assigned according to the disorder that was most severe according to the F-DIPS (0 to 8 scale); c) if disorders from different categories were equal in severity, the subject was assigned according to the earliest onset of disorder.

**Procedure**

Interviews were administered by a highly trained and experienced survey staff consisting of psychologists, medical doctors, and graduate students in psychology. During interview training, F-DIPS sections were practiced extensively, and a prefield training was performed. These steps were followed by ratings of four practice interviews. Two practice interviews were conducted before starting fieldwork. Interviewers were supervised biweekly. Each interview was taped, and supervisors randomly reviewed tapes. Every interview was proofread by trained supervisors.

**Worry Interview**

The GAD section of the F-DIPS included questions about the frequency of worry content separately for the following life domains: daily hassles, work or education, family, finance, social/interpersonal, personal health, health of others, society and world, and other (miscellaneous) topics. For each of these domains, the presence of worry was asked for, and worry frequency/intensity was ranked between 0 (never, no problems) and 8 (all the time, very strong problems); for example, “Are there any worries about work or education? If so, how intense or frequent are these worries?” Worry topics were defined as clinically relevant when rated at least 4 on the respective 8-point scale, indicating a medium degree of worrying (intensity/frequency).

**RESULTS**

**Frequency of Clinically Relevant Worry Topics in the Diagnostic Groups**

Table 1 shows the percentages and the 95% confidence intervals (CIs) of women in each of the diagnostic groups who suffered from worries in each worry domain. Only worries that were rated 4 or higher by the interviewer are reported. Women with GAD had the highest percentages of worry in every worry category. Although worry is common in depression and other anxiety disorders, it was significantly higher among those with GAD. Additional analyses computing odds ratios (ORs) showed that GAD was significantly
more commonly associated with each type of worry content compared with healthy controls (OR, 7.4 to 32.7, all significant) and those with other anxiety disorders (OR, 3.0 to 11.6, all significant), with the exception of daily hassles (OR, 4.7; CI, 1.0 to 18.4). GAD was also more commonly associated with worry over family (OR, 48; CI, 5.8 to 20.60), health of others (OR, 5.7; CI, 1.1 to 56.2), and health of self (OR, 9.3; CI, 1.1 to 418.4) compared with those with affective disorders. Almost three of four women with GAD had clinically significant worry about both work and family.

**Uncontrollability of Worry Among Females**

All participants rated the degree of uncontrollability of their worries regarding the different topics. Again, the scale ranged from 0 (total control) to 8 (no control), with 4 signifying a clinically significant degree of uncontrollability. Table 2 shows the means and SDs of uncontrollability per topic. Because only participants who had a severity rating of 1 or more for each topic were included, the numbers of participants varied greatly for the different topics and groups. Table 2 also shows the means and SDs for all groups and all topics. All eight analyses of variance (for each topic) were significant (all $F > 9.5$, $p < .000$). Those analyses were followed by comparisons of GAD versus healthy participants, GAD versus anxiety disorders, and anxiety disorders versus the healthy group. The GAD group differed significantly from the healthy participants in regard to every topic (all $F > 17.1$, $p = .000$). The same was true for the uncontrollability ratings of the anxiety disorders, which were all significantly higher than those of the healthy group (all $F > 51.5$, $p > .000$) Although GAD was consistently associated with the highest level of uncontrollability, the level of uncontrollability was not significantly higher than that associated with the other anxiety disorders in all cases.

**DISCUSSION**

Our results suggest that worry in GAD is most commonly characterized by concerns about work, family, and finances, but not daily hassles, which is in contrast with our predictions. Based on findings from clinical studies, we predicted that worry about daily hassles would discriminate between those with GAD and other mental disorders. Unexpectedly, only 10% of the women with GAD worried about daily hassles. The differences in findings between our study and those from clinical samples, which are considerable, may suggest that the content of worry associated with GAD in the population differs from the content for those who seek treatment. Level of uncontrollability of worry among those with GAD significantly exceeded that among those with other mental disorders. Of interest, women free of mental disorders report almost perfect control of worry, regardless of the content. Limitations of this study should be noted when interpreting results. First, these data are generalizable only to females in the community. Because potential fears and worries in the everyday lives of males and females may differ, future studies will be needed to determine whether these findings are generalizable to males. Second, although the

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<th>Table 2. Controllability of Worry Topics for the Different Diagnoses*</th>
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<td><strong>No Disorder</strong></td>
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<td><strong>M (SD)</strong></td>
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<tr>
<td>Daily hassles</td>
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*Means and standard deviations for the controllability ratings (0–8).
sample size is relatively large overall, the cell size for some less common disorders was too small (e.g., eating disorders) for reliable statistical comparison in some cases. Replication of these findings will be needed with larger samples. Overall, these findings are consistent with previous findings suggesting that GAD is a distinct clinical syndrome with unique phenomenology, rather than a disorder that occurs only when comorbid with other affective or anxiety disorders. Our results also suggest that clinical data on GAD may not be generalizable to the community; therefore, future studies on GAD in the community, including males, will be important in increasing our understanding of GAD and in improving early or public health intervention efforts for GAD in the general population.

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REFERENCES